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CAUSES AND CONSEQUENCES OF ALCOHOL ABUSE

HEARINGS

BEFORE THE

COMMITTEE ON GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

PART 2

ALCOHOLISM TREATMENT
JUNE 16, 1988

ALCOHOL ABUSE PREVENTION
SEPTEMBER 27, 1988

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ALCOHOLISM TREATMENT

THURSDAY, JUNE 16, 1988

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:40 a.m., in room SD-342, Dirksen Senate Office Building, Hon. John Glenn, Chairman of the Committee, presiding.

Present: Senators Glenn, Chiles, and Bingaman.

OPENING STATEMENT OF CHAIRMAN GLENN

Chairman GLENN. The hearing will be in order.

Good morning and welcome to the third of four hearings that the Governmental Affairs Committee is holding on the causes of and governmental responses to alcohol abuse and alcoholism. At the previous hearings on alcoholism last month, this Committee heard testimony from the Administration, from experts in the biomedical and social sciences, State alcohol and drug abuse directors, and an alcohol abuse policy organization on what Federal and state governments are doing in the areas of alcohol abuse research, treatment, and prevention.

From the testimony we received at these hearings, it is clear that alcohol abuse and alcoholism are complex disease processes that will require imaginative solutions for effective treatment and prevention programs. Alcohol abuse and alcoholism are among this country's most serious economic and public health problems. While I do not wish to diminish the impact that the use and sale of illicit drugs has on our country, in our zeal to eradicate abusive substances in our war on drugs, we often forget that the use of alcohol, a legal drug, is exacting a heavy toll on our society. In fact, I think you could make a case that it is still far more important than all of the illegal drug problems combined.

Alcohol abuse currently accounts for 100,000 to 200,000 deaths annually. Nearly one-half of all accidental deaths, suicides, and homicides are alcohol-related. In a single year, alcohol-related traffic accidents claim somewhere over 18,000 lives. It has been estimated as high as 24,000 or 25,000 some years, some years a little bit lower. To put this in perspective, in the entire Vietnam War, the United States lost 57,690 lives. More than 62,500 lives are lost each year to alcohol-related diseases, motor vehicle accidents, homicides and suicides.

In addition, the abusive consumption of beverage alcohol has been associated with an increased risk of developing liver diseases, hypertension, cardiovascular disease, and certain forms of cancer.

The National Institute on Alcohol Abuse and Alcoholism estimated 3 years ago, in 1985, that there were approximately 18 million adults, persons 18 years of age and older, who were alcoholics or alcohol abusers. I think the figures break down to about 10 million people that are actually alcoholics and about another 8 million that are problem drinkers who are on the verge of alcoholism. There are an additional 4.6 million adolescents who have experienced problems associated with the consumption of beverage alcohol.

Based upon current estimates, the number of dependent alcoholics is expected to increase by almost one million people by 1995. That is just 7 years from now; another 1 million people.

In 1987, this Nation spent almost $500 billion on health care, yet 20 percent, or almost $100 billion, of these hospital care expenditures were alcohol related. In a study conducted by the NIAAA between 1980 and 1983, alcoholic families were found to use health care services and incur medical costs at nearly twice the rate of similar nonalcoholic families.

Total health care expenditures can be reduced by alcohol treatment. Within 2 to 3 years following the start of treatment, the average alcoholic's treatment costs were offset by reductions in other health care expenditures. Moreover, survey data collected by the American Hospital Association found that since the early 1970s there has been a continual increase in alcoholism treatment services and of the numbers of people in treatment.

Despite the range of medical and social problems associated with problem drinking, and the expansion of alcohol abuse treatment services available, fewer than 15 percent of alcoholics and problem drinkers receive treatment for their condition. This means that the majority of alcoholics and problem drinkers receive no treatment at all for their problem.

Alcohol abuse and alcoholism have many causes and affect diverse groups of individuals. No one treatment program or treatment strategy will be appropriate for everyone. Clearly, the earlier we were able to identify and treat persons for their alcohol dependency or problem drinking behaviors, the lower the social and economic costs of alcohol abuse will be to our Nation.

Our hearing today will examine the types of public and private alcoholism treatment services available in this and other countries, how effective these programs are in treating problem drinking behaviors, what the barriers to seeking treatment are among problem drinkers, and what is being done to meet the special treatment needs of adolescents, women and minority clients.

We are truly honored in having with us today the leading researchers and practitioners in the area of alcohol abuse treatment and rehabilitation services providers. We appreciate your cooperation and your coming to the hearing today. Thank you all for agreeing to participate in this and we look forward to an absorbing day of testimony.

Our first panel is on Alcohol Abuse Treatment: Options and Efficacy. The panelists are Dr. Joan Jackson, representing Alcoholics Anonymous, Bethany, Connecticut; Dr. Damian McElrath, the Hazelden Foundation, Center City, Minnesota; Dr. William Miller, University of New Mexico, Albuquerque, New Mexico; and Dr. A.

Thomas McLellan, University of Pennsylvania, Philadelphia, Pennsylvania.

If you would take your places at the table please, we would appreciate it, and we look forward to your testimony. I would warn you in advance, those microphones are not the most sensitive in the world. We would appreciate it if you would pull them up very close and speak right into them, as close as you can, so everyone can benefit from your testimony.

Dr. Jackson, would you lead off for us this morning, please.

TESTIMONY OF JOAN K. JACKSON, PH.D., REPRESENTING ALCOHOLICS ANONYMOUS, BETHANY, CT [1]

Dr. Jackson. My name is Joan Jackson. I am a trustee of Alcoholics Anonymous, one of the minority of trustees who are themselves not alcoholics. I am a sociologist by training and my background is research and teaching in alcoholism.

I have been asked to discuss the AA philosophy of the treatment of alcohol abuse and to describe the AA program. To do this, I will delineate briefly what in my opinion are important beliefs, principles and processes of AA.

AA is a loose organization of self-help groups made up of persons who wish to stop drinking because they have experienced problems in living when they drink, who do this by following a program of 12 suggested steps which have helped those who preceded them to solve these problems.

While the only requirement for membership in AA is a desire to stop drinking, most of those who come to AA have tried and failed often and seriously enough that their lives are organized around these efforts and around trying to hide from themselves and others the seriousness of their problem. Most have experienced disastrous accompaniments to drinking.

AA provides a culture integrated around the single purpose of helping alcoholics to recover. It stresses the responsibility of the individual to make decisions for himself and to choose his own course of action as a result of these decisions. It provides a milieu in which hiding from himself and others is no longer relevant or possible. Members of AA understand his feelings and his problems. They will discuss their own experiences with him, but it is up to him to decide whether or not he is an alcoholic, whether to attend meetings, who to discuss his problems with, whether to follow the suggested steps, and how.

He is advised to attend meetings and to keep an open mind, to use what he hears, if it is useful, at any given time, and to leave the rest. If he finds nothing which is meaningful in one group, he is advised to try others. At the same time, he has before him examples of people who he knows have been like himself and who are now building satisfactory and rewarding lives and he has a tendency to follow their examples.

No pressure is put upon him to make any long term commitments, but rather to make commitments for manageable time intervals and to renew them again at the end of the interval if he still wishes to do so. For example, to decide not to drink for 24 hours at a time. Nothing is required of him beyond what he undertakes or offers voluntarily. At the same time, his decisions and his efforts towards recovery are supported by other AA members.

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[1] See p. 105 for Dr. Jackson's prepared statement.

Recovery begins with a self-diagnosis of alcoholism, or short of this, with the acceptance of the impossibility of controlling or stopping drinking without outside help. AA believes that alcoholism is an illness with physical, psychological, social and spiritual aspects, that it can never be cured, only arrested. In order to have alcoholism remain in remission, the individual must be abstinent and abstinence can only be maintained if he changes his way of thinking and behaving.

The 12 suggested steps are considered to be the route to effecting these changes. These steps involve a willingness to change, to ask for help from others, and from a power greater than themselves, whether this be the group, an undefined spirit, or a traditional God, and to accept responsibility for defining his personal, social and spiritual problems and for taking action to change them.

This involves taking a personal inventory and making amends to those he has injured. The result, it is hoped, will be an abstinent person who is honest with himself and others, whose guilt has been alleviated as he has done all he can to set the situation straight, and a person who will continue to accept responsibility for his feelings and behavior and hence who will cope with problems more realistically.

He will live in an environment in which he has close, understanding and accepting friends who support him in his efforts to become the person he wants to be. Having benefitted from his AA experience, he is expected to help other alcoholics set foot on the same path. This activity, known as 12-step work, is defined as making a crucial contribution to his own recovery. It requires him to continually relive his own thinking and behavior at the time he came to AA, keeping the likely consequences of the resumption of drinking always before him.

AA groups, like AA members, are autonomous. They are loosely linked together around the 12 suggested steps and around 12 traditions. These traditions guide the relationship of AA members with each other and with the outside world.

Important among these traditions are self-support through their own contributions, the restriction of AA's activities to its primary purpose, the recovery from alcoholism of its members and of potential members, not engaging in any controversy or having any opinions on any outside issues, cooperating with others who help alcoholics to recover but not affiliation with any such programs or any other organization, and most important of all, the tradition of anonymity.

This anonymity tradition not only provides protection for members but also has what AA terms strong spiritual implications. It symbolizes the importance of the group over the individual, of principles over personalities, and the sacrifice of personal gain and individual ego satisfaction, which is regarded as necessary to effective recovery.

It should be added that AA does not concern itself with the causes, types or severity of alcoholism, only with the acceptance that alcoholism is the problem. The causes are in the past. The program is concerned with what can be done from today onward.

The AA program and philosophy are described in various AA publications and in their book, *Alcoholics Anonymous*. Samples of these have been sent to the Committee.

I have also been asked to comment on the demographics of AA members. AA does not solicit identifying data from individuals. Hence, characteristics of its membership are imperfectly known. There are more than 800,000 currently active members in the U.S. and Canada and an educated guess would be that there are at least that many who are sober but no longer active.

There are at least another 700,000 members in more than 100 other countries. Membership is heaviest around the major cities of this continent, particularly on both coasts. About one-third of our members are women and about 20 percent are under 30, with this proportion increasing at a really remarkably rapid rate. All racial and ethnic groups in this country are significantly represented.

I have also been asked to comment on the utilization of the AA approach to treatment in other alcohol treatment settings. We cooperate widely with professionals and alcoholism treatment programs, primarily by making AA resources available to them for the long term maintenance of sobriety. We are aware that our program has been incorporated into many treatment programs and that large numbers of our members assist treatment programs. However, we do not regard it as within our traditions to monitor such uses, and hence details are more appropriately presented by those who use our help.

Concerning the effectiveness of the AA approach. First, AA does not believe it is possible for an alcoholic to return to normal drinking. Secondly, we have no hard statistics on how many have achieved sobriety through the AA program. We do know that a third of our present members have been sober less than a year, about a third sober 1 to 5 years, and a third over 5 years. The extent and continuing rapidity of our growth suggests that large numbers of alcoholics have achieved lengthy periods of sobriety on AA. For more rigorously derived information, however, we must refer you to those who do follow-up studies of treatment programs.

Thank you.

Chairman GLENN. Thank you very much, Dr. Jackson.

Dr. McElrath, you represent the Hazelden Foundation, and we would appreciate your testimony. Thank you for being here.

TESTIMONY OF DAMIAN McELRATH, PH.D., THE HAZELDEN FOUNDATION, CENTER CITY, MN

Dr. McELRATH. Thank you, Senator Glenn, ladies, and members of the staff and Committee.

My name is Damian McElrath. Previous to coming to Hazelden I was president of a small eastern university and I was a professor at the Catholic University of America. Presently I am the director of all of Hazelden's residential programs, both adolescent and adult.

Your letter requesting my appearance before the Committee was quite clear in your directions. You asked me to please cover Hazelden's philosophy of treatment, description of the program, demographics of our clients, utilization of the Hazelden approach and discussion on its effectiveness.

You have the written testimony which I submitted[1] and I shall summarize it since it is much more than 10 minutes—not my summary.

Chairman GLENN. If I might interrupt just one moment, all of your more lengthy statements will be included in the record. We do have a number of witnesses. That is the only reason we ask you to summarize where possible. But where you feel that there are parts of your statement that you would like to give in its entirety before us, that is quite permissible, too.

Dr. MCELRATH. Thank you. I shall try to cover these points clearly and succinctly. First, as to our philosophy of treatment. When Hazelden was founded as a not-for-profit hospital in January of 1949 the attitude toward alcoholism and chemical dependency was still characterized by a phrase which I call the old awareness; namely that the alcoholics were hopeless, a great deal of pessimism about doing anything for him or her, and he or she deserved to be punished for his crime.

The new awareness that alcoholism was and is an illness, that it is treatable and arrestable had not yet become a part of the consciousness and conscience of American society. The alcoholic was an outcast, a pariah.

The following is a typical example. In 1940, the man who was to become the first director of Hazelden, a lawyer of some standing in Minneapolis/St. Paul showed up at a Catholic hospital for some help in the middle of one of his binges. The Catholic chaplain was called for who proceeded to tell Mr. Carol in no uncertain terms that either he leave the hospital grounds immediately or he would call the police. Things were pretty difficult when one could not get help from either the clergy or a hospital.

Now, no judgment is being made. It was just a sign of the times. Hazelden was founded at a time when that self-help group, Alcoholics Anonymous, was taking strong roots in the Midwest. Thus, the ground was already being cultivated for the Hazelden Minnesota Model. AA was responsible for the ideas, as was just mentioned, that alcoholism was and is an illness in itself; two, that it can be arrested; three, that the image and stereotype of the alcoholic as the skid row or bowery bum represents only 3 percent of the population with alcoholic problems; four, that the other 97 percent are board members, professional people, as doctors, lawyers, clergy, educators, and with all due respect, politicians of both political persuasions. Indeed, alcoholism is the most democratic of all diseases, and the Russians are discovering that, also.

Hazelden learned a great deal from AA. As a matter of fact, it became the core of its program from the beginning. Our philosophy is simple. We tell all the patients who come to us that as good human beings but chemically dependent, they have the potential to abstain from mood-altering chemicals. And secondly, they have the potential to change their behavior.

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[1] See p. 116.

Abstinence and changed behavior are what set the Hazelden Minnesota Model apart. If you look at these goals clearly, you will see that conversely they describe the illness of alcoholism. Scientifically, alcoholism is an illness deriving from a pathological relationship with mood-altering chemicals and resulting in dysfunctional behavior. Translated into common language, I drink too much—a pathological relationship—I get in trouble—a dysfunctional behavior.

Initially, the program at Hazelden was very simple. I like to think that it still is. In 1948 there were four elements to the program: First, to conduct oneself in a properly decent fashion; two, to make one's bed; third, to attend the lectures; and fourth, to talk to one another. It is refreshing to know that the same elements remain the core of the program. I have described it in my own book on *Hazelden: a Spiritual Odyssey,* how the core revolves about the central principle of communication or dialogue, what Bill Wilson described as the recovery process occurring with two alcoholics to one another over a cup of coffee. And while the program indeed has become more structure in terms of groups, one-on-ones, the assessment process, treatment planning, after-care planning, quality assurance, and so forth, the core principle of communication remains the same. You have to talk to one another, you have to substitute for the devastating intimacy with the chemical that has developed. An intimacy with other human beings has to be substituted, which can only be accomplished through the one thing that makes us to be truly human, the power to communicate.

There was one thing, however, that did evolve in the decade of the 1950s that became another essential part of the Minnesota Model, and that was the multi-disciplinary team. Indeed, it was a natural complement to the understanding of the illness concept which describes alcoholism as a multiphasic illness affecting every dimension of the alcoholic—physical, cognitive, social, emotional and spiritual.

Consequently, we have physicians, nurses, psychiatrists, psychologists, clergy, social workers, recreational specialists, and chemical dependency counselors, the latter being in charge of the treatment team.

The Minnesota Hazelden Model then is one that first believes chemical dependency is a primary illness; second, the AA program and process is essential to recovery, a program that inculcates abstinence; third, that a multi-disciplinary team is the best way to respond to this multiphasic illness; and fourth, that each chemically dependent person is worthy of dignity and respect and that Hazelden's environment itself should demonstrate that.

Regarding your next request about demographics of Hazelden, let me provide you with an executive summary of the written information that has been submitted. The 1986 patient profile reads like this. In 1986, there were 1,655 admissions to primary care only. The male and female ratio was 2 to 1; the ages varied from 16 to 76, the average age being 37; 44 percent of those admitted were married; 30 percent were college graduates; 27 percent had some college education; and 26 percent were high school graduates; 79 percent of those were employed; 94 percent reported problems with alcohol; and 10 to 47 percent reported problems with drugs; 32 percent madc a personal decision to seek help from Hazelden; and 43 percent had a portion of their fees paid by insurance; 81 percent left with staff approval; 85 percent were referred to Alcoholics Anonymous; and 80 percent were from outside of Minnesota.

I think by this time you can discover that I am not from Minnesota but from New York and as a result maybe I can speak more objectively to the Minnesota Model. I am not sure.

Now, you have asked for any information I might have on the utilization of the Hazelden approach to treatment in other alcohol abuse treatment settings. I can answer only in generalities. In 1986 it was estimated that almost 95 percent of the treatment centers in the United States are based—although some loosely—on the Hazelden Minnesota Model approach.

At this point I would like to interject a thought or two to clear up any misconceptions. This first is that when I am speaking of the Hazelden Model, the ideas and practices contained in that Model also reflect what is called the Minnesota Model. Thus, while the Hazelden Model and the Minnesota Model can be used interchangeably, there are a large group of treatment services in Minnesota that deliver what is called the Minnesota Model.

There is another major misconception, that the Hazelden or Minnesota Model is narrowly conceived of as a 28-day primary inpatient treatment program. I would like to correct that misconception. In the past 40 years the Minnesota Model has developed a continuum of care for chemical dependency that includes prevention of alcoholism, early intervention, long term treatment for the chronic relapser, and the promotion of high level recovery for chemically dependent people and their families. So it is not just to be conceived of or limited to a 28-day inpatient primary program.

The continuum of care evolved as a practical response to the observation in Minnesota that all clients bring different situations to treatment. Some who have strong social support networks and a less severe history of chemical dependency may need only outpatient treatment. Others may need residential care, extended treatment over several months, halfway houses and various forms of after-care counseling.

Families, too, vary in their needs for education and support. What I want to say in the strongest terms is that in the last analysis, outpatient care as a less restrictive and less costly service was there in the Minnesota Model long before managed health care thought they invented it. The continuum for care for chemical dependency evolved as a practical and cost effective response to the different levels of care required by different patients. The current practice of managed care often usurped this humane, beneficial approach.

Finally, just a few words about outcomes. Hazelden has been measuring the effects of its care since the establishment of its evaluation department in 1970. As with its goals, it seeks to measure both the behavior of the individual and the abstinence. Our 1986 survey result showed this, that one year after treatment 68 percent had never used alcohol and 11 percent had tried alcohol only one time; 87 percent had never used drugs, or had used them only for medical reasons; and 5 percent had tried drugs only once after treatment.

To support their sobriety, most—77 percent—of these patients attend Alcoholics Anonymous. The great majority of these patients report improved relationships in all areas of life. After treatment, patients report improved relationships with spouse, family and higher power, and much improved personal growth.

Employers benefitted from an employee's treatment as absenteeism, tardiness, accidents and hospitalizations dropped after treatment. At the same time, job performance and satisfaction improved.

My written report shows all of these points in great detail. Hazelden does not do controlled client longitudinal studies. Although very useful, that is not the type of research we are about.

The success of our program is measured in the fact that since 1949 about 70,000 patients have gone through Hazelden's programs. We are very aware that we have helped most of these patients and their families change their lives in significant ways. We are certain also that we have not helped some of them. But we are more certain that because of the treatment that was offered, these people refer other ones to us. And that is how we measure the success, that the people that have gone through say, that is a good problem, it has worked, and we will send people back to you. We take great pride in what we do.

Finally, I want to thank you for the opportunity to appear before you. I hope this brief presentation is what you desired and will be helpful. Thank you for you attention.

Chairman GLENN. That was very helpful, Doctor. Thank you very much and we will want to get to questions shortly. All that buzzing of the clock back there meant that we are on a vote over there. We will try and spell each other here. Senator Chiles will go ahead and vote and then try and get back here so we keep the hearing's continuity going. If not, we will have to recess temporarily while I go vote also. So he will get back as fast as he can.

Senator Bingaman wanted to be here when Dr. Miller, in particular, testified. We will leave you until last here. He will be here in just a moment, I am sure, after he votes.

Our next witness will be Dr. A. Thomas McLellan, from the University of Pennsylvania, Philadelphia, Pennsylvania.

Dr. McLellan, we welcome you this morning and look forward to your testimony.

TESTIMONY OF A. THOMAS McLELLAN, PH.D., UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA, PA[1]

Dr. McLELLAN. Thank you very much. Before I read the prepared text, I would just like to say the three points that I think are most important in the text that I will be presenting. I hope they are simple and straightforward.

First, treatment is effective. There are a variety of existing treatments and there is good clinical and experimental evidence, to show that they are effective; second, treatment can be delivered more cheaply. It can be delivered cheaply in two ways; greater use—not exclusive—but greater use of outpatient care; and second, matching patients to existing treatments to take better advantage of the particular strengths of the individual kinds of treatments.

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[1] See p. 135 for Dr. McLellan's prepared statement.

The third point is that both the amount and quality of treatment needs to improve. Quantity is a function of funding pretty much exclusively. But the quality of treatment is really a function of training. Unlike most other medical specialties, we do not have an infrastructure. We do not have a long existing history of sustained training and research. And that is the other way quality of treatment can improve, with more research.

Substance abuse treatments are demonstrably effective. A summary of several studies performed in the Veterans Administration and other clinics revealed that treated alcoholics have shown average decreases of 61 percent in the amount and frequency of their drinking, and average increases of 78 percent in their employment earnings in the year following treatment.

Similarly, treated drug abusers have shown average decreases of 58 percent in drug use, 67 percent in criminal activity, as well as increases of 55 percent in employment earnings in the year following treatment.

Substance abuse occurs in conjunction with other serious medical, psychological and social problems. These problems may be caused by or result from substance abuse, but if these problems are not addressed in conjunction with the substance abuse treatment, they leave the patient at an increased risk for relapse.

At present, few treatment programs have the professional resources to focus on anything except the addiction. Research is accumulating which shows that the addition of appropriate professional interventions, such as marital and family counseling for associated family problems, psychiatric care and medication for associated emotional problems, employment and skills training to increase self support, can enhance and measurably extend the benefits of standard alcohol and drug abuse treatments.

In this regard, it will be especially important to attract and train an infrastructure of professionals to deal with these and other problems of addicted individuals. This may be the single most important goal in the continued efforts to prevent and treat substance abuse.

Three, the number and severity of patient's alcohol-related problems can predict outcome from different treatment intensities, that is, inpatient versus outpatient. For example, patients with better—and this should come as no surprise really—patients with better social supports and fewer psychiatric problems do equally well in inpatient or outpatient forms of treatments. Treatments of patients in outpatient care is by our research 7 to 10 times cheaper than inpatient care of the same type. Patients having more serious psychiatric problems and/or fewer social supports do less well in most treatments generally but particularly poorly in an outpatient setting.

Patients can be matched to treatments. Studies performed within the Veterans Administration have shown that by using standard patient background information, patients can be assigned to the most appropriate and cost effective treatment, and matched patients had significantly better outcomes at follow-up and were less likely to return to treatment than mismatched patients treated in exactly the same programs. This resulted in an overall improvement of treatment efficacy of 37 percent in an already effective treatment network, and an average savings of $3,700 a patient.

Chairman GLENN. Doctor, I really do hate to interrupt but I am going to have to go vote because I am going to miss the vote if I do not get over there right now.

We are going to stand in recess for a few minutes. I really hate these truncated hearings, but these are the facts of life on Capitol Hill. So I do hate to interrupt your statement and we will get back as fast as we can.

Thank you.

[Brief recess.]

Senator CHILES [presiding]. I think we will try to start. Senator Glenn will be back momentarily.

Dr. McLellan, I understand we interrupted you so we will let you just take up.

Dr. McLELLAN. Shall I start over or shall I continue?

Senator CHILES. You can just continue.

Dr. McLELLAN. Fine. The point that I was on was that patients—based on our research—can be matched to treatment. Studies performed within the Veterans Administration have shown that by using standard patient background information patients can be assigned to the most appropriate and cost effective treatment. Matched patients in our studies have had significantly better outcomes and were less likely to return to treatment than mismatched patients treated in exactly the same programs by the same staff. This matching resulted in an overall improvement in treatment efficacy of 37 percent in an already effective treatment network and a savings of over $3,700 per patient that was treated.

Senator CHILES. Now, explain to me quickly what matched is.

Dr. McLELLAN. You will hear many times that approximately 50 percent, say 60 percent of patients treated do well. You also have conceptually and methodologically different types of treatments available; from an outpatient Antabuse type of treatment to an inpatient 30-day AA-oriented treatment.

Is it possible that it is not the same 50 percent of people getting better in each of those two very different programs? Would it be possible to match the kinds of people who were likely to do well in program A, to program A and those who were more likely to do well in program B with that program?

That is the matching hypothesis and that is the kind of work that many of us have been doing, and in fact we can do that. And when you do it, we find that patients like it better, staff like it better, patients improve more than they would ordinarily and you can save some dollars. Essentially, that is the story.

My final point is that there is a need for more innovative interventions. In particular, there has been a concentration of research attention and treatment dollars on the initial detoxification stabilization phase of care, right up front. Much less attention has been devoted to the post-treatment adjustment and integration of the patient into society. Yet this is the point at which most patients have trouble and are at most risk for relapse.

There has been a tremendous amount of research in the treatment of alcohol and drug dependence over the past two decades but very little of it has translated into modifications of the basic treatment process. In some quarters, the suggestion that new treatments are needed has been considered defamation of existing methods. In fact, there is every reason to feel heartened by the efficacy shown by existing treatments.

However, the results of treatment evaluations, patient treatment matching studies and many others indicate that no single treatment is effective for every patient, that many patients have been admitted to inpatient treatments when short term, less intensive/extensive treatments could have worked, and that many other patients will not accept or benefit from existing interventions.

The creation of these new and more innovative, more applicable treatment interventions I think will come through the training of an infrastructure of professionals in this field who can sustain effort, research, training, teaching and clinical practice. And that, I think, more than anything else is what this field lacks. If you look at cardiology, oncology, any other medical specialties, there is a long history of sustained funding. I am not talking about a lot of money, but the thing that this field has lacked, in my judgment, has been sustained moderate amounts of funding for training, for treatment and for treatment research.

That really would be my final pitch to this Committee, that in fact, the quantity of treatment ought to be expanded, but that is simply a matter of funding. Funding is not easy to get, but that is all it takes. But the quality of treatment also needs to improve and that is not simply a matter of funding. That is a function of additional training and additional research. I will stop with those comments.

Thank you very much.

Senator CHILES. Thank you.

Dr. Miller, we will take your testimony.

TESTIMONY OF WILLIAM R. MILLER, PH.D., UNIVERSITY OF NEW MEXICO, ALBUQUERQUE, NM

Dr. MILLER. Thank you and good morning. I am honored by the invitation to speak to this Committee and I particularly thank you all for your interest in alcohol abuse as a drug problem.

I am Dr. William Miller from the University of New Mexico where I am professor of psychology and psychiatry and also director of clinical training.

Alcoholism treatment effectiveness has been my primary research interest for the past 15 years, though I am not associated with any particular treatment program. I currently hold 4 Federal grants to study various interventions for alcohol problems and I have held several others over the past 10 years. I have been a treatment research consultant to the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, and the National Academy of Sciences.

You have asked me to address six very complex and formidable questions and to give you the bottom line on all six within 10 to 15 minutes. I will do my best. Where time fails me, I have given your staff extensive documentation of what I will say and I will be glad to answer your questions.

The first question you asked me is, "What do we know from current research about the effectiveness of various alternative treatments for alcohol problems." To do this, I must first address the rules of evidence and standards of proof with an example. Suppose a drug company developed a new medication for alcoholism and they found a group of 200 people with alcohol problems and gave them all this new drug. One year later they contacted them by questionnaire or telephone and heard back from 160 of them. Of the 160, 80 said that they were now sober. The company announces the drug to be 50 percent effective. Is that good or not?

It is almost impossible to say. You would want to know, for example, who were these people and how serious were their problems to begin with? How accurate was their self report? Were they just telling the investigators what they wanted to hear? What else may have changed in their lives during that year that could account for their improvement? What about the 20 percent who were not located? And most unanswerable, how many of them would have shown such improvement without the drug? Would it be 30 percent? Or perhaps 70 percent?

In short, such an uncontrolled report is very difficult to interpret because the outcome could be explained in so many different ways. There are so many other factors that could have caused the outcome.

There are about 400 such uncontrolled studies in the alcoholism treatment literature. These are commendable and helpful efforts but do not lead us to confident conclusions. Happily, there are remedies for these shortcomings in the scientific method, as those of you will know who have been trained in science. A properly controlled clinical trial, which is the accepted standard of evidence in medicine, directly compares a treatment with no treatment, or a placebo, or an alternative form of treatment. From such a properly controlled trial, one can judge the effectiveness of a treatment relative to a comparable group given a different treatment. We require drugs to pass such tests before they become accepted treatments.

There are about 200 controlled studies of various alternative treatments for alcoholism and that is what I want to summarize for you. This summary you will find in table 1 of my written testimony, which is page 4. To give you the briefest summary of that, there is reasonable evidence for 8 different kinds of treatment methods, and I will not detail, unless you are interested in them, what those treatments are.

"Reasonable evidence" I have defined as at least four positive controlled clinical trials and of all the controlled studies available, at least 50 percent of them are positive. There are 19 other alcoholism treatment modalities which lack such evidence at the present time.

Concluding on this question, we have available a variety of effective treatments for alcoholism. There is no single outstandingly effective treatment method, and all treatments are not equal in their effectiveness.

The second question you asked me is whether there is a gap between current practice in the field and what has been learned from

Federally funded research. Simply put, yes, there is an enormous gap. What the eight research-supported treatments have in common is that they are rarely used in U.S. treatment programs with, I must say, the exception of VA hospitals where they are more often used.

On the list of methods in table 1 upon which most U.S. programs are based, none of these components has been shown to have a specific beneficial effect with alcoholism in controlled clinical trials to date.

Concluding on this question, research-based treatments are seldom used in the United States. Current practice relies on largely unproven methods and the American utilization of research-based methods has been mostly within Federal programs—that is, research and VA hospitals.

The third question which you addressed to me is how treatment setting affects outcome. There are 20 randomized clinical trials of residential versus non-residential treatment, or longer versus shorter hospital programs. Nineteen of these studies found no advantage at all for residential over outpatient programs or longer over shorter programs for unselected patients. All 11 of the studies that have appeared within the past 10 years have shown no difference.

This is consistent with the conclusion of the World Health Organization in 1951 that hospital treatment is rarely necessary for alcoholism, and with your own Office of Technology Assessment report which appeared and was given to the Congress in 1983.

The caveat that I would give here is the same offered by Dr. McLellan, that there may be a sub-population for whom intensive treatment is more effective and perhaps even more cost effective. From current evidence, that would be the socially unstable person, the homeless, indigent, unemployed, and severely impaired people, those who are severely addicted to alcohol. In short, those who may need such treatment are unlikely to be able to pay for it themselves.

The fourth question you asked is the one which Dr. McLellan has addressed on matching, so I will not give great detail to this except to say that although two treatments may not differ overall, their effectiveness may be quite different for specific sub-populations. Treatment should therefore be tailored to the needs of individuals rather than a standard program being offered to all, and treatment systems therefore should offer a range of alternatives from which treatment plans can be constructed on an individualized basis.

The fifth question is how effective are brief interventions in reducing alcohol problems and the news here is very good. "Brief interventions" I would define as 1 to 3 sessions, usually consisting of structured advice and feedback given to the individual. These can be done outside the formal alcoholism treatment system. They can be offered in primary medical care and health settings and also in educational systems.

There are seven randomized clinical trials of brief interventions and all seven have shown them to be more effective than no treatment. That is, a very brief intervention causes significantly more change than no intervention at all. There are seven other randomized clinical trials comparing brief treatment with more extensive treatment and six of these have found no differences in impact over time.

This appears to be a very cost effective kind of intervention and appears to be most effective with people who are less impaired—for the problem drinker, and so it is a good early intervention.

Concluding on this question, brief intervention is a cost effective secondary prevention strategy and brief intervention is a sensible alternative to try first instead of putting people on a waiting list and instead of trying first expensive formal treatments.

Lastly, you asked me to address how U.S. alcoholism treatment systems differ from those in other nations. I must first confess the limit of my experience in this area. I have consulted for four Canadian provinces, lived 6 months in Norway and worked there in the alcoholism treatment system. I have visited in alcoholism hospitals and clinics in the Soviet Union, Sweden, Denmark, Germany, England and Scotland. But I profess no knowledge of treatment programming in Africa, Asia or South America, so my contrast will be primarily with Canadian and European systems.

With that caveat, however, I can give you a number of points in which our system differs dramatically from other nations. The most obvious difference, of course, is that our health system is privatized and has a substantial for-profit base whereas the health systems in these other nations are primarily social medicine with a nonprofit base. Cost effectiveness has therefore been a much more pervasive concern in these other nations for a very long time, although we are seeing that in this country now with the emergence of health maintenance organizations and prepaid medical care plans.

In relation to that, this country has placed much more emphasis than any other on the use of hospitals for treating alcoholics. In other countries, emphasis is given much more to community based treatment. This county also has given much more of a disease treatment emphasis whereas other countries have taken much more of a preventive public health focus in dealing with alcohol problems within the society in general.

Intensive treatment has been emphasized strongly in this country, whereas brief and early treatment, again with a preventive focus, is much more common in the other nations with which I am contrasting our programs.

We in this country have tended to think of alcoholism as a binary diagnosis—either you have it or you do not—whereas as other nations have seen much more of a continuum of alcohol problems and have tried to address all levels of severity of alcohol problems in society. In this country we have relied historically upon recovering paraprofessionals as the primary treatment agents, and that is a very unusual fact in other countries where health care professionals are the primary people dealing with alcohol problems.

This country's alcohol treatment programs are strongly guided by the Alcoholics Anonymous disease model whereas in other nations, the public health World Health Organization model is much more prevalent. Finally, in this country we have emphasized an abstinence-only kind of goal, that the only option one has if one has an alcohol problem is to stop drinking completely for the rest of one's life, whereas in other countries a continuum of goals are considered. In society, the population is encouraged to reduce alcohol consumption and problems on a society-wide basis.

To give you the very bottom line then, first, a number of alternative approaches have been found to be effective in the treatment of alcohol problems, based on well-controlled Federal and non-Federal studies. They are rarely used in the United States outside of Federal research and VA treatment settings.

Second, standard practice in the United States is based on a combination of components which have not been shown to be effective in properly controlled clinical trials thus far.

Third, residential treatment yields no higher overall success rate than less expensive non-residential alternatives. Longer hospital stays have not been shown to be more effective than shorter programs in controlled clinical trials. Intensive treatment may be better for the socially unstable and severely addicted.

Fourth, there is no single superior treatment approach for alcoholism. The best approach depends upon characteristics of the individual. Thus, an optimal treatment system would offer a variety of research-based alternatives, designing different treatments for individuals based on their own needs and problems.

Fifth, specific and relatively brief interventions have been shown to reduce long term alcohol use and problems. These are cost effective and broadly applicable methods. Research indicates that these brief treatments are better than no treatment and comparable in impact to more extensive treatments in many cases, at least with better prognosis, early populations.

Finally, U.S. alcoholism treatment systems differ substantially from those currently used on other nations which stress community-based early intervention with a broad range of alcohol problems. The American hospital-based program relying upon a confrontational disease-focused counseling, administered by recovering alcoholics is a relatively rare approach on the world scale.

Chairman GLENN. Thank you, Dr. Miller. Thank you very much.

We will go on the 5-minute rule here since we have several of us here on questioning, at least in the first round.

How do we measure effectiveness of these different approaches internationally? I wondered what the approaches were of other nations. You touched on it briefly there. Is the effectiveness that they have any better than our approach?

Dr. MILLER. Well, it is very difficult to compare across nations. I can give you an example of a Swedish study in which the outcome measures were 5-year health care utilization, and a very brief intervention conducted by Dr. Hans Kristensen was demonstrated to produced significant decreases in diseases, mortality, and health care utilization over a 5-year span relative to people not given the brief intervention.

But to compare absolute levels from one program to another, even within the same country, is very hazardous, let alone across boundaries. I can say that other nations, in my opinion, appear to have used research-based techniques—even though it is American research—more than has been the case in this country.

Chairman GLENN. Dr. McElrath, you have looked at this international thing. You have a particular approach at Hazelden. Have you looked at these other models from other countries to see how their effectiveness compares with the Hazelden program? And what were the results of such a look?

Dr. McElrath. No, not really. I am not that research-oriented as Professor Miller is. I spent some time in Sweden myself and I think what I would like to say is that if something works, use it. It is as simple as that.

But our approach is very simple. The outcomes are very good. One of the things that I would just like to comment on is I really favor also this matching idea, that people should be matched to treatment, and if you would allow me one minute, I would like to demonstrate how that is working in Minnesota.

As I said, I am in charge of the adolescent program out there at Hazelden and about 3 or 4 years ago the legislature wanted to do something about the juvenile court system, that many of the juveniles were being sentenced and if they were not put in jail, they were put in treatment centers. And there was a large outcry about that. And so they wanted to review and revise the juvenile code. And moving from juveniles that were indeed welfare and so forth, they moved over to the area of juveniles that were ill—mentally ill or chemically dependent. And they were attempting to establish an elaborate court system whereby they could determine whether these people really needed treatment.

Now, I am saying that because at the same time that was going on in Minnesota, we began as a result of the citizen committee in 1981, a huge research program in an attempt to come up with an adolescent assessment tool that would be able to satisfactorily determine how bad the situation or difficulty was with the child and how we could match that child to treatment so that the less structured treatment would be given to that child.

We put $700,000 into that. It was all privately funded. It came out of foundations in Minnesota. We had good validity studies on it and it is in effect right now, the Western Psychological Association. But I mention that only as an example to, not confirm or back up, but to say that we also are interested in matching people so that we are not giving them, or putting them into confinement, or parents are not putting them into treatment because they do not know what to do with them.

Chairman Glenn. Follow up on that if you would, though, or if all of you would comment on that, I would appreciate it, because, who does the matching? Let's say I have a problem. I probably have hidden this up until the last minute and then, bang, I have got to go get help.

Who do I go to to say I am best matched to an outpatient, an inpatient, or whatever type program? Usually you grab whatever is available in the local community in a situation like that and there is not any consideration of matching until maybe much later on after having gone through some of this you would have some idea, well, maybe if I had done this differently it would have been more appropriate.

But who does the matching? And where do you go to get matched up?

Dr. McElrath. I think you have a good point, but what I tried to bring out in my paper was that what has developed in Minnesota is not simply a 28-day primary inpatient program. There is a whole continuum of care that has developed there, just as in medicine you have a whole continuum of care from prenatal care to hospice care. So there is a large continuum.

What developed in Minnesota was a large continuum also so that at the beginning what we have in the communities themselves, in all the communities in Minnesota, are, for example, diagnostic assessment cells, or diagnostic assessment components. So those people, if they have good diagnostic tools and assessment tools, would be able to match the person to treatment.

Chairman GLENN. Dr. Jackson, does Alcoholics Anonymous do any matching or screening? Or is yours abstinence and a support group to back that up and that is it?

Dr. JACKSON. No. AA places no restrictions whatsoever on who comes to it. They take everybody who comes, but it is self-determined that they are coming, usually. Although more and more lately they are being sent there by courts, too.

Chairman GLENN. How do you do the matching?

Dr. MILLER. Well, you have perceived what is a very important problem. There is research to indicate that each program tends to take most everybody who comes and to recommend whatever it is that they happen to offer. I think what really is needed is some sort of independent treatment brokering system or diagnostic service that has no affiliation with any particular treatment program.

We have tried to set one of those up in Albuquerque with regard to drunk drivers so that rather than sending them to particular treatment agencies, there is an unbiased independent evaluation service that sees the person and determines what of all the options available might be best for the individual. I think that is a relatively rare idea and one toward which we might move.

Chairman GLENN. Dr. McLellan?

Dr. McLELLAN. I think there are mechanisms, though they have not been used.

Chairman GLENN. Well, give me an example. My time is up here in the first 5-minute round. But if you could briefly give me an example. If I am in trouble right here, say, where would I go in Washington to get matched up?

Dr. McLELLAN. Right. I do not want to extend it too much, but you have to really ask the first question. What do you want? What do you expect to get from alcohol treatment? And what should we expect from an alcohol treatment? Should you drink less after you have had alcohol treatment? Should you be abstinent? Should you be employed? Should you have no more marital problems? Just what is expected here?

And further, it has to be broken down. I think you are seeing now a move in many insurance companies to treat the various stages of alcohol treatment discretely. And so it is possible to make several matching determinations. Your pre-admission groups now are doing screenings to determine if—for detoxification alone—you need an inpatient facility versus an outpatient. Completing that stage of it, they do another evaluation and they say, well, now, you want to go on for rehabilitation, do you need an inpatient facility? Do you need a resident facility? Do you need a medical facility? Or do you need outpatient care?

Okay. Now you are finished 30 days of rehabilitation. What are the additional problems that are going to impede you from maintaining that abstinence and continuing your sobriety? Okay. Maybe now is a point where you bring in some of the after-care services. And you need alternatives to match. If there is one only show in town you cannot match. And you are getting more shows in town and the insurance companies are recognizing that now.

Chairman GLENN. Senator Chiles.

Senator CHILES. I would like to just ask each of you, what is the most important thing that we could be doing up here to try to assist treatment? I know dollars. But what are the things that we could most effectively do?

Dr. Jackson, we will start with you.

Dr. JACKSON. Well, speaking for AA, I have to invoke the tradition that we do not have any opinion. We will accept what you do and we hope you do things but we have no opinion.

Senator CHILES. Dr. McElrath?

Dr. MCELRATH. I probably should say I do not have any either, but I do. I think that you have to take a look—well, do not take this as a personal affront—but I think everybody has to be educated in what this whole process is. And I think that the Senate or the Legislature has to take a good hard look at the whole continuum of care that is being introduced, namely in terms of prevention education, in terms of intervention and treatment, and third, in terms of health promotion, in much the same way that it is done with the addiction to tobacco.

And an education process, a prevention process, an intervention process—I think that those areas should be subsidized. But I think you are doing the right thing. I have heard a lot of important things myself. You have got to find out what are the best programs. But it is education itself.

Dr. MILLER. I guess I would have two points. I would concur with Dr. McLellan that money carefully invested in research on treatment, how well it works, is well invested and that has been underfunded in this country, in my opinion. But I think, also, we need to take a careful look in this country at how we deal with alcohol more generally. We have tended to think of alcoholism as a strange disease that people inherit, and that is an unusual view unique to this country.

Other countries view alcoholism more as what happens to people if they drink too much and take serious governmental efforts to reduce alcohol consumption in the whole population, and I think we have not done that very carefully. It is very consistent with health promotion efforts. It is more what we have done with tobacco. I think there are a variety of legislative routes through which the population could be encouraged to drink less alcohol; education being one of them, excise taxes being another. I think any effort that can be made toward reducing alcohol consumption in the general population is likely to have a good impact in reducing alcohol problems.

Dr. MCLELLAN. I would have an immediate concern. I guess put bluntly, I would urge you not to join the latest war on drugs and alcohol. The reason I say that is I am a veteran now of four wars on drugs and when the public, the press and funding agencies begin to see this as a nasty situation that has suddenly cropped up, you have a war, and you arm for it and then it is over. It is considered something like a nasty spill of toxic wastes on a river. You clean it up and then you go away.

What that leaves is unmanageable amounts of money that come in right away and dissipate immediately and you have extraordinary waste. What I think is needed is stable, moderate levels of funding in partnership with groups and organizations that have an established interest in the field. I would envision partnership programs with medical schools and professional institutes to train—I keep saying—the infrastructure that is going to sustain this. This is not a war. In fact, I do not think you can win a war on alcohol and drugs. This is a sustained effort that needs to have low-level, moderate amounts of sustained funding. That would be my big pitch.

Chairman GLENN. Senator Bingaman.

OPENING STATEMENT OF SENATOR BINGAMAN

Senator BINGAMAN. Thank you very much, Mr. Chairman. I do have a statement I would like to include in the record, if I could.

Chairman GLENN. Without objection.

Senator BINGAMAN. Thank you very much.

[The prepared statement of Senator Bingaman follows:]

PREPARED STATEMENT OF SENATOR BINGAMAN

I wish to commend my good friend and distinguished colleague, Chairman Glenn, for his leadership in organizing this important series of hearings on alcoholism. Alcoholism is a disease of epidemic proportions in this country, and like all diseases, its elimination can be achieved only through a serious commitment to prevention and treatment. I am pleased that this Committee has joined the fight against this deadly disease.

The witness list for today's hearing is long and distinguished, and I am particularly proud that it includes one of the leading researchers in the field of additive behavior research, Dr. William Miller from the University of New Mexico. Dr. Miller has spent the past 15 years researching the effectiveness of alcoholism treatment and is the director of the University's doctoral training program in clinical psychology. We can learn much from his excellent research and testimony, and I look forward to insightful comments.

Dr. Miller's testimony and that of all the witnesses who will participate in this series of hearings is particularly important to my home state of New Mexico because of the degree to which alcoholism has impacted its citizens. Many studies, some of which will be discussed during these hearings, confirm that the need to wage a serious war against this disease is long overdue. The need is critical among all people, but I believe it may be most critical among our Native American population. The incidence of alcohol and drug abuse among Indian people is tragically high, perhaps higher than that of any other population in the U.S.

Many critical health problems afflict our Indian population, but always the number one problem remains the same: Alcoholism and alcohol-related diseases, injuries and death. It is, as recognized by this Congress, "the most severe health and social problem facing Indian tribes and people today."

Perhaps the tragic scope of this problem was best explained by Gilbert Pena, past Chairman of the All Indian Pueblo Council in New Mexico. During Senate testimony on Indian health two years ago, he said:

"The most obvious and vicious threat to the lives and well-being of our Pueblo people is the damage brought on by alcoholism-related destruction. Alcohol is a contributing factor in most of the motor vehicle accidents in our communities. Many of the costly hospital admissions are in some way connected with alcohol abuse.

"However, in terms of the substantial cost of primary care and the strain on this nation's budget, economic cost is really nothing compared to the social cost to the Tribe. An extremely important part of the Indian culture and tradition lies in the sharing of experience and wisdom between the elders and the young people. Given the tragic rates of accidents and death among the younger age groups, it is easy to see how the social order is severely impacted. Many promising young Indian leaders are now a part of the statistics."

The findings of *The Statistical Summary of Child Evaluation Surveyor* for the Shiprock Service Unit of the Indian Health Services further reveal the magnitude of the problem. Of the adolescents surveyed by the Indian Health Service in a community with 10,000 children between the ages of 10 and 19, 40 percent were diagnosed as suffering from alcohol-related disorders and 23 percent were diagnosed as suffering from drug-related disorders, including "hard-core" chemically dependent adolescents, many with multiple drug and alcohol abuse problems. Of the youths suffering from severe family disfunctions, 70 percent had parents who abused alcohol or drugs. Perhaps the most disturbing finding concerns treatment rates. Of those surveyed, 40 percent were considered in need of treatment for substance abuse, but only 5 percent received it. Of those needing in-patient treatment (48 percent), only 5 percent were treated. Likewise, only 8 percent of the 88 percent considered in need of family therapy or counseling received it. And of the small number who did begin therapy, 60 percent failed to keep any treatment appointments after the first few sessions.

As these statistics so graphically illustrate, the need for effective preventive-education programs and localized in-patient and out-patient treatment services for our Native American population is absolutely critical. I am hopeful that through today's excellent testimony we in the federal government may learn of ways to best fund and implement these types of programs and services.

Certainly some excellent programs exist, but as I read through our witnesses testimony, two unmistakable themes emerged: Prevention—early intervention through comprehensive family and community-based education—is the key to controlling the alcohol epidemic, but so far we have failed to commit ourselves to any serious national efforts to combat the disease through education. And just as we have neglected our role in preventing the spread of alcoholism, so too have we neglected our role in effectively treating its victims.

Through long-term and wide ranging studies, such as those undertaken by Dr. Miller at the University of New Mexico, we have an idea of what works and what does not work, and we are currently funding a wide-range of treatment programs. But we in the Congress have not made a serious effort to ensure that those in need of care and treatment are getting the best care that our resources can provide.

These hearings are evidence, I believe, that we can rectify these critical shortcomings. Without a doubt, we can no longer ignore a problem as great as the alcohol epidemic; instead, we must be willing to commit ourselves to winning the war against its spread. We have the weapons needed to win—education and effective treatment, we must only begin. I challenge every member of this body to join our fight. Thank you.

Senator BINGAMAN. Comments were made about how we emphasize the use of hospitals; that is, how we treat alcoholism as a disease. I think, Dr. Miller, you were making this point in your testimony. We emphasize the use of hospitals to a much greater extent than most countries do, and we do not pursue treatment through brief intervention. We do not use intervention as a standard type of treatment, or really any other type of treatment that is research based.

Is that because of the incentives, the way are medical system developed through Medicare, Medicaid and various insurance programs that compensate people for treatment? Do we push people into the treatment our economy emphasizes because of these incentives? Should we be trying to make intervention more accessible? Is that something with our whole approach to alcoholism?

Dr. MILLER. Well, it is no surprise that economics will influence the treatment system and it is clear that alcohol treatment is a very good profit-making industry at the present time. So that our current incentive systems, I believe, favor hospital treatment. There are coverage plans, for example, in which all of hospitalization will be covered but if one wishes to receive outpatient care you must pay for half of it yourself. Such incentives are going to increase the use of hospital care.

It also is the case that private programs tend to keep people longer than publicly funded programs do. You can see in case after case the influence of economic incentives on how we treat people. If the situation is different, as it is in a social medicine country and an HMO where it cost the system a lot more to hospitalize a person, then there is much less use of hospitalization.

Senator BINGAMAN. You also made the point that we use a public health approach to this problem less than other countries. Is one of our major problems the advertising of alcohol products through television and other media? Is that a major problem? One of the school principals in my state said that he had read that the average student sees about 18,000 beer ads before he or she is old enough to legally buy beer.

Is that a problem, if we wanted to take a public health approach? The political obstacles are enormous, but I am just asking, if we were seriously going to pursue a public health approach to reducing alcoholism, would we have to deal with advertising as well?

Dr. MILLER. I think it is significant, and I guess the investment made in advertising says that the liquor industry also thinks it is significant.

Senator BINGAMAN. The industry thinks it is significant?

Dr. MILLER Well, a lot of money is spent on advertising that to me portrays a very positive image of alcohol in general—that it does very good things for you. There is little to counteract that image in the media. I probably would give higher priority to increasing the price of alcohol. I think you are more likely to have an immediate impact of that than with alteration in advertising. But I think it is a significant issue that our children see so much in the way of messages that say alcohol is a good thing and makes you feel good and changes you in positive ways.

Senator BINGAMAN. You also cited the World Health Organization model of treatment. I was not here for all of the testimony, but could you elaborate on what that is? We are not using that model, I gather from your statement.

Dr. MILLER. Well, it is more the public health perspective, that this is a problem that is influenced by individual difference factors, by environmental factors, and by the agent itself. And the World Health Organization takes more of a continuous dimension than an "either you have alcoholism or do not" perspective.

So they are concerned with alcohol consumption in nations. They are concerned with low-level general problems in the population, as well as severe alcohol problems. We have tended to think in terms of and focus our treatment toward the most severe kinds of alcohol problems in this country. It is not incompatible. It is just that we have been focusing on a relatively small portion of the larger dimension of alcohol problems.

Senator BINGAMAN. You know, we keep talking in our latest drug war, and maybe the three previous "wars" also, about naming a czar, somebody who is in charge of dealing with the drug problem. This Committee's jurisdiction is primarily in the area of the structure of our Federal Government.

Is some restructuring required for us to implement a national policy or a national strategy to deal with this problem? Do any of you have opinions on that?

Dr. McLELLAN. My opinion—and it is only that—is that you have an existing structure, and a very good one. HHS works fine. It will work better with the kind of sustained funding that would give alcohol and drug abuse the same kind of prominence that cardiac care, cancer research and treatment now has. Of course, they get a lot more money, but they also have—and I keep saying it—an infrastructure, people who learn how to do that kind of treatment, learn how to evaluate it, learn how to develop it. And that is what I think has been lacking.

Possible mechanisms for this could include an alcohol tax. It could include a variety of things. But that, of course, is your business, not ours.

Senator BINGAMAN. Does anybody else have thoughts on our structure?

Dr. MILLER. I concur. I think you have a good structure in place and it just needs to be used. I also concur that large amounts of money in one big flood are not a very good idea. Much of it gets wasted and it is appropriate to run moderate funding through the existing channels that are fairly conservative and have the money spent responsibly.

Senator BINGAMAN. Thank you, Mr. Chairman.

Chairman GLENN. I think one of the difficulties here is I think there are 13 different Government agencies that have some part in the drug program, whether it is working in the foreign areas to prevent production to begin with, the transportation out of that country, interdiction someplace else, interdiction at our borders, the local community, police efforts, education efforts as the long term solution.

The problem is they have all been operating in sort of a disjointed way. The Majority Leader here asked a number of us to be part of a panel to put together a program that we could recommend and those recommendations are supposed to be in at noon today, as a matter of fact. It just happened that way. HEW has part of it, but there are things like INS and Customs and a whole bunch of people that get into the act on this, that are not being coordinated now, and that is our problem.

That is where if you have somebody that can coordinate all of these other functions outside HEW that you mentioned, I think maybe it can have some benefit. I do not know.

The war on drugs, as you say, I think—I am not trying to downplay that. I think it is important we put some effort into it. But I think the alcoholism thing by the numbers involved, the numbers of families affected, people affected, dwarfs almost what is going on in the hard drug field. So I think we need some change in organization.

The other way, which would be almost impossible to do if we do not appoint somebody to coordinate these things, would be to say we take those functions out of all these different places and make a new agency of some kind, and I just do not see that we could do that. That would be an enormous job. It would be very disruptive, too, and I am not sure it would be a more effective organization once you had it formed. So it is a real problem.

Dr. McLELLAN. I should make clear, my comments were directed towards the goals of treating and preventing alcohol and drug abuse. You are quite right, preventing drugs from entering our borders and all that kind of stuff really is much different.

Chairman GLENN. We are talking about alcoholism being a disease. Is it a genetic problem mainly? Is it something that is acquired? If we think of a disease, and it is termed that, are we developing a shot for it? Do we have an antibiotic that will cure you from being an alcoholic or prevent it to begin with? That is a natural reaction if you say it is a disease.

We have in the smoking area, what is it? Antabuse? I think it is, as a way to help you—or what is Antabuse?

Dr. MILLER. That is for alcohol.

Chairman GLENN. That is for alcohol. That is right. That is not nicotine. That is for alcohol. It apparently works a little bit for some people sometimes. Does that offer some promise? Are we doing enough in the research area? Not just to gather statistics, but are we doing enough basic physiological and biological research to try and develop something like this where you could give a kid a shot like you do for measles and know that he would never develop an alcohol problem?

Is there any promise of anything at all along that research line?

Dr. MILLER. There is quite a lot of research of that kind happening now, in fact, more than there is of treatment research. I think there are clearly genetic components to alcohol problems for some people. I personally think we have tended to over-emphasize that perspective in this country with the belief that alcoholics are somehow qualitatively different from normal people. That is a comforting view for the rest of us but it does not seem to be scientifically true.

It looks more that alcohol problems are continuous and the more you drink the more difficulties you run into. It is important to maintain the basic research and I think some very promising things are happening there. I would also encourage us to look at control of the substance itself inasmuch as that is feasible, and to look at environmental factors that influence people to use alcohol.

Dr. McLELLAN. I would like to add just a few words. Your own words are quite right. The size of the alcohol problem in this country and other countries dwarfs drug problems. Now, is it reasonable to believe that every one of the people who are affected by alcohol abuse have a genetically or metabolically different kind of body than those who are not?

I think not, actually. You must realize that alcohol abuse and alcoholism comes in all severities, strikes at all stages of life, and here is the most important thing—it rarely occurs alone. You see it in conjunction with other "tiny little" problems like poverty, lack of education, depression, medical complications, spouse abuse, child abuse, poor rearing, "little tiny" problems like that that none of us have had any kind of success in dealing with, and they are thrown at the feet of the alcohol treatment and drug abuse treatment people to cure along with the alcohol and drug abuse.

So I think while it is extremely important to pursue an active program of basic biological research—and many strides have been made and a report is coming out from the National Academy of Science in that regard—you must put it in the context of the whole problem.

Chairman **Glenn**. Senator Chiles?

Senator **Chiles**. Well, I had a lot of questions, but I think that what you are saying is very interesting. So there is a genetic thing, but the question is, that is not the only reason that we have got 12 million plus alcoholics; is that right?

Dr. **McLellan**. It is like hypertension. There are genetic factors in hypertension. Not every single person who is hypertensive is so because of his genes. Some are that way because of their diets. Some are that way because of stress. Some are that way because of combinations of things.

Senator **Chiles**. If the genetic factor was there, you probably might have more of a problem, or a problem more quickly, but without the genetic factor you still could become an alcoholic?

Dr. **Miller**. Yes. It is a risk factor. You can have higher risk of developing the problems based on your genes.

Dr. **McLellan**. One in two of all psychiatric admissions in this country have an alcohol problem. This is a large population in people, 1 in 2 of those have an alcohol or other substance abuse problem. A large proportion of people with primary drug abuse problems have alcohol problems.

It does not occur alone, is all I am saying. It occurs in conjunction with other very serious problems that may have nothing to do with the original etiology of the alcoholism itself but certainly will complicate the treatment of the alcohol and drug abuse.

Chairman **Glenn**. Senator Bingaman.

Senator **Bingaman**. No further questions.

Chairman **Glenn**. Gentlemen, I wish we could go on all morning but we cannot. We have two other panels we have to get to. We may have additional questions to submit to you. We would appreciate a response so we could include that in our record. Other members that were not able to be here this morning may have questions also and we would appreciate your response to those.

It is intensely interesting. It is a mammoth problem. It is one that has been much too much accepted. One of the purposes of our hearings is to focus a little bit more attention on this in our own way here and hope that we can get something done.

I would only ask one more question before we let you go, and I was not going to do this, but I do want to ask, for long term prevention, is education of our young people, is that the—how do you make it peer popular not to drink instead of the other way around? Just the horror stories that you may wind up in an accident sometime, there may be blood and guts all over the highway if you drink—the scare tactics I do not think have been all that successful. Maybe some of them have, but I do not think they have in general.

What approach would you take to try and reduce this long term over the next 20 years? I am responding to your comment about we have a war and it is down. And if we are going to have a long term sustained program, we could be instrumental here in setting up some of that long-term program and seeing that it got funded if we thought it was going to do some good.

What would you suggest? Yes, Dr. McElrath.

Dr. **McElrath**. One suggestion that I have, I think, is we know that adolescents are a strange breed. And that is not a putdown. That is the way they are. They go through their developmental tasks. They act out a great deal. When that is compounded with alcohol it is very difficult to discern. What do we have here; just acting out behavior or an alcoholic problem?

But the one suggestion I would have—again, it comes back to education—is that we introduce into our high school or even grammar school system some prevention or health promotion program so that the school board, the teachers and the students are alerted from top down that this could be a problem, there are other ways of getting highs, there are alternate highs.

At the same time in the school system I would not urge that people cannot drink or use when the legal age occurs. But I do believe that in the high school and grammar school systems we introduce some prevention program, educational program. And it is being done in many areas.

Chairman **Glenn**. Do other nations use any different approach?

Dr. **Miller**. Well, certainly pricing and the control of advertising is widely used in other nations. I think that the expectancies that we give our children about alcohol and drugs and tobacco and all the substances that get abused are very important. There is research now demonstrating that children who have positive expectancies about what alcohol will do for them begin drinking at a younger age—these are prospective studies—and are more likely to get into trouble with alcohol.

The same kinds of positive expectancies predict relapse to drinking in alcoholics after treatment and anything that creates that sort of positive image of alcohol in the minds our children I think is pushing in the wrong direction.

One of the most successful prevention programs—one of the few successful prevention programs with adolescents—emphasized that factor and taught children how to contradict advertising. It literally started with ads and said, what is the theme that you are being told? What is the message that you are getting about what alcohol does for you? And what is the truth?

So education to contradict the positive messages that are around about alcohol and tell what the true effects are, and teaching kids—I think one of the positive things about the "Just Say No" approach is at least teaching kids skills, social skills, to resist peer pressure. That also seems to be helpful.

But I would add that any prevention program done in schools must have an evaluation component attached to it because these things can backfire and some of them have actually increased alcohol and drug use even though they were intended to prevent. So that anything done on a school-wide or statewide or nationwide basis ought to have a very good evaluation component so that we know we are in fact preventing.

Chairman **Glenn**. For every alcohol ad would you say that there has to be an anti-alcohol ad or time made available?

Dr. **Miller**. That would be an interesting approach actually, equal time, so that rather than trying to ban advertising, to have an equal time component that provides health messages regarding the true effects of alcohol, which I think most of the country is not aware of.

Chairman **Glenn**. Talking about as a general health program, do the medical schools concentrate on this? My son is a doctor. He is an anesthesiologist out in San Francisco and I have talked to him about this some, and in medical school they got little or practically nothing on alcoholism per se. It was not hardly even addressed. It was just brought up sort of as a side issue that there is a problem out there that may be coming before you some day.

Is that sort of the way it is approached?

Dr. **McLellan**. Yes, it is.

Chairman **Glenn**. Maybe that would be the first step, to really teach something about this as part of a general health program.

Dr. **McLellan**. Absolutely. Again, I think that is extremely important in medical schools because there is the view still, after all the wars on drugs and alcohol, that there is a very select group of people that drink 60 cent sherry out of a bag while lying on a grate that are alcoholics. And if you are a cardiologist or, you know, you want to get into internal medicine or something, you will never have to worry about that.

Well, in fact, that is exactly wrong, and it is quite pervasive. And though it is very difficult to instill these kinds of things into a cramped medical curriculum, that is what needs to be done.

Chairman **Glenn**. Thank you very, very much. We may send you some questions as a result of this. It has been very interesting. We appreciate your being here. I wish we had all day to talk about this because it is one of, if not our very largest health problem we have in this, and I believe that. And all you have to do is look at the statistics that you people have developed in some of your organizations to prove that that is the case. So we want to do whatever we can.

I would solicit your help on this, too. If you have suggestions, write to us, whether we request it or not. We really are truly interested in doing something about this. Write to us. Write to Lawton Chiles, me, Jeff Bingaman here and we will see what we can do on this without our asking you questions about it. We are just trying to set up programs that will prevent some of this carnage and this devastation of our people into the future, and that is all we are trying to do.

You are the experts in this field. Give us your advice.

Thank you much.

Our next panel is on Alcohol Abuse Treatment Programs. Our panelists are: Mr. Paul Lubben, President of the National Association of Alcohol and Drug Abuse Counselors of Arlington, Virginia; and Dr. Ron Fletcher, Director of the Ohio Department of Health. Ron we are glad to welcome you this morning here. Thank you for coming in today. And Ms. Deborah Beck, President, Drug and Alcohol Services Providers Organization of Pennsylvania, from Harrisburg, Pennsylvania.

We welcome the three of you here to address our problem of alcohol abuse treatment programs.

Mr. Lubben, would you lead off, please?

TESTIMONY OF PAUL LUBBEN, PRESIDENT, NATIONAL ASSOCIATION OF ALCOHOL AND DRUG ABUSE COUNSELORS, ARLINGTON, VA

Mr. LUBBEN. Good morning, Mr. Chairman and members of the Committee. My name is Paul Lubben. I am the Director of the Oakview Chemical Dependency Treatment Program at Southwest General Hospital in Cleveland, Ohio. At Oakview, we provide treatment for alcoholism and drug addiction, both on an inpatient and an outpatient basis. I have worked in the alcoholism treatment field for the past 17 years and I became a certified alcoholism counselor in 1978.

I am representing the National Association of Alcoholism and Drug Abuse Counselors, of which I am President-elect. NAADAC is a professional association representing the interests of more than 22,000 counselors in all 50 States. The Association is dedicated to promoting quality treatment for alcoholism and drug addition through professional involvement in the treatment process.

Alcoholism and drug abuse counselors are the front line staff and backbone of alcoholism treatment programs. For many years counselors entered the field for largely altruistic reasons, including gratitude for their own recovery from this serious condition.

However, as the profession has grown and developed, it has increasingly become the profession of choice by individuals who place great emphasis on service to others.

Certification as an alcoholism counselor is awarded to individuals who have developed and demonstrated knowledge and skills in alcoholism and drug abuse counseling as measured by experience, professional references and written and oral examinations. The CAC or its equivalent in each State is the only professional credential currently available which assures the public and those seeking help for alcohol and drug abuse problems that the professional holding this credential has demonstrated competency in alcoholism and drug abuse counseling.

Alcoholism and drug abuse counselors have eagerly sought to improve themselves and their profession and have actively supported the development of competency based certification systems within the states. Anticipated Federal direction in the development of standards for counselor certification was not realized through the 1970s until a final product and report was issued in 1985. This Birch & Davis report outlined standards for alcoholism counselor certification systems. By the time the report was issued, most States had developed their own certification systems and as a result, the present certification is State based.

Certified alcoholism and drug abuse counselors are the core of the professional team in treatment settings, yet their salaries remain unrealistically low. The frequency with which counselors change careers and move to other fields—as high as 30 percent every 2 years in Ohio—represents a tremendous loss of essential personnel resources in our profession and the whole alcoholism and drug abuse treatment field. High stress associated with the job dramatically adds to the burnout and turnover rate.

NAADAC is working to correct this problem by upgrading the profession, strengthening the certification systems and advocating for more resources to provide alcoholism and drug abuse treatment by certified counselors. Federal leadership in training, career development and the direction of treatment resources to organizations which insists on certification of their employees who provide counseling services is crucial to success in this area.

NAADAC supports using strong Federal leadership in the area of alcoholism education, prevention and treatment. Under that leadership in the 1970s great strides were made in increasing the awareness and acceptance of alcoholism as a treatable disease and recognition that alcoholism is not a respecter of position, profession or economic status. In fact, it is a pervasive disease which affects all aspects of our society and people in all walks of life.

Improvements in work site employee assistance programs in recent years, third party coverage for alcoholism and drug abuse treatment as well as a dramatic increase in public and private treatment programs have partially removed the stigma which prevents alcoholics from getting vitally needed help. This has been a tremendous benefit not only to the alcoholic but to their families, employers and the community at large.

However, there still remain serious obstacles to the individual seeking treatment for alcoholism. Stigma, moral judgment and outright discrimination continue to block access to treatment. The moralization about the alcoholic as an individual who is totally to blame for his own condition is alarming and inconsistent with assuring quality care and access to this care for our citizens. In spite of significant advancements in knowledge about treatment, treatment approaches and treatment outcomes, it is increasingly common to find conditions imposed upon entry which block access. These conditions may include provision for treatment in only one modality, such as only a psychiatric facility, or only a detox facility, or only a hospital or only outpatient treatment.

The Federal Employees Health Benefits Program is unfortunately one example of unrealistic limits placed on treatment through a benefit plan. This has the unfortunate result of blocking access to clinically appropriate and cost-effective treatment. In addition, minimal coverage provided by Medicare and Medicaid programs restrict access to care. In particular, outpatient coverage is inadequate to provide comprehensive outpatient care. As a result, this places increased costs on the third party payer, the health care system and results in inappropriate and occasionally poor quality treatment.

Many public programs are pushed beyond their limits and simply cannot respond to the overwhelming number of individuals seeking treatment for alcoholism. If our society is serious about addressing the devastating effects of alcoholism, we must assure uncomplicated access to treatment on demand by any alcoholic who desires it.

Federal leadership in assuring Federal employees of adequate coverage is crucial. Concerns about the cost of this coverage have been addressed successfully through a variety of research which documents cost savings to the employer and the third party payers by means of reduced medical utilization after treatment. If we do not treat alcoholism appropriately, we will pay dearly for the variety of expensive medical and social consequences which alcoholism causes.

In addition, access to treatment for many employed Americans is now threatened by Federal plans which provide no coverage for alcoholism treatment. NIAAA has funded research studies which demonstrate the efficacy and cost-effectiveness of insurance coverage for alcoholism treatment and has proposed model benefit plans. In spite of this, S. 1265, currently on the Senate calendar and the House Companion version contain no specific coverage for alcoholism and drug abuse treatment. Enactment of this legislation would preempt State-mandated coverage now in place in the majority of the States.

Enactment of this legislation without a specific provision for alcoholism and drug abuse treatment would set the field back significantly and leave millions of Americans and their families without adequate coverage for this treatable illness.

The Block Grant Funding Program has allowed more local discretion to direct resources toward areas of most need. However, the remaining overwhelming need is for an increase of funding of all types for education, prevention and treatment efforts. The change in the funding method was traumatic for the overburdened public treatment system which depends on the Block Grants for its survival. As there remains concern about under-served populations, the set-aside funds for women, minorities and others have focused much needed attention on these populations. However, the overall picture is one of gross under-funded programs reduced to shuffling severely restricted dollars from one under-served group to another without the solid basis of on-going funding in place to assure stability and quality care. In spite of these factors, there are many examples of fine quality public programs doing an excellent job with severely limited resources.

As you have stated, Mr. Chairman, almost all of the money appropriated for fighting alcohol and drug abuse goes towards the eradication of illegal drugs in the United States. Some of these funds could certainly be better used in education, prevention and treatment programs.

The private alcoholism treatment system has grown dramatically in the last decade. There remains room for improved coordination between the public and private treatment systems. In Ohio, for example, public funds are generally spent in public programs. Private hospital programs generally do not spend public funds, other than Medicaid and Medicare, for their treatment services. As a result, the two systems tend to function independently.

Although the environment is increasingly competitive, the competition is not for patients so much as for the severely limited resources available to treat the enormous untreated population of alcoholics. Cooperation on training, education, prevention and treatment is needed, but more significantly, expansion of the public system capacity for treatment is crucial to our efforts. Federal leadership in this area is important.

In summary, we at NAADAC believe that people affected by alcoholism and drug addiction have the right to clinically sound, cost-effective prevention, intervention and treatment, employing professionals who are trained in the specialty of addiction. We support national standards for counselor certification. We want to reassure you, Mr. Chairman, that we will continue a vigorous program to continually attract, train and upgrade to the highest professional level counselors dedicated to our goals.

Despite new funding and improved national attention to alcohol and drug problems, Federal policy clearly is not where it should be and in many cases it is apparent that we are losing ground. Stigma and moral judgment are very much with us as it applies to alcoholics, both in the Supreme Court and in the halls of Congress.

On April 20th, the Supreme Court ruled that the Veterans Administration can deny certain benefits to alcoholic veterans on the ground that their disability is the result of willful misconduct. In the House, there have been recent attempts to exclude alcoholics and alcohol abusers from anti-discrimination protections extended to disabled persons under the Fair Housing Act. The recent debate on the Civil Rights Restoration Act drew comments about a law which would force the hiring of alcoholics and drug addicts.

As an organization concerned about quality services for alcoholic patients and their families, NAADAC views this increasing moralization and punitive attitude toward the problem with concern. The rights of alcoholics and drug addicts to adequate treatment must be protected, and removal of these rights would present new barriers to treatment and recovery for millions of Americans suffering from alcoholism and certainly complicate our attempts to deal successfully with the problem.

The common element in all of these issues is the need for Federal and Congressional leadership. This series of hearings under the leadership of the Committee is the single most important attempt to review alcohol policy our organization has seen over the last years. Anti-drug abuse legislation is again before Congress with new opportunities to include policy and funding measures to adequately address alcoholism and alcohol-related problems.

This Committee has an opportunity to move and refocus the nation's agenda toward a more comprehensive and human plan to reduce alcoholism and alcohol related problems. Today the knowledge to make major improvements in reducing the effects of this illness is available to us and the National Association of Alcoholism and Drug Abuse Counselors is willing to work in cooperation with you to meet this goal.

To achieve these goals, Mr. Chairman, we make the following recommendations. Federal and State agencies should support if not mandate the increased use of credentialed alcoholism and drug abuse counselors. In addition, these agencies should support education and training for new and current personnel. These actions are essential if we are to provide on a continuous basis a high level of professional treatment nationwide.

Second, a percentage of all forfeiture and/or assessed conversion monies collected from illegal drug trafficking should be directed to alcoholism and drug abuse treatment, prevention and research.

The Federal Government should alter its present position with regard to the health insurance coverage for treatment of alcoholism and drug abuse for all Federal workers. The House of Representatives in the 1986 Omnibus Drug Bill included provisions which would authorize demonstration projects to test the efficacy and cost effectiveness of new treatment and rehabilitation programs under the Federal Employees Health Benefits plan. Unfortunately, these provisions were not considered in the Senate. Action should be taken this year to make available full benefits for treatment of alcoholism and drug abuse to every person in the Federal work force.

Education, prevention, and treatment should receive at least equal consideration and focus with enforcement activities in all legislation authorizing and appropriating funds to be spent in alcoholism and drug abuse.

Mr. Chairman, we commend you for your foresight and leadership in initiating these hearings, and we commend you, Mr. Chairman, for your cosponsorship of S. 2047, which would require warning labels on alcoholic beverages, and we stand ready to work with you and your staff in any way possible to help win this so-called latest war on alcohol and drug addiction.

I will be pleased to respond to any questions that you or other members of the Committee might have.

Thank you.

Chairman GLENN. Thank you very much, and we will save the questions until after everyone has read their testimony.

The next witness is Dr. Ron Fletcher, Director, Ohio Department of Health. Ron, we are glad to have you with us this morning. You have had a very active program back home in Ohio and we would be interested in hearing more about it so everyone can benefit from it.

We look forward to your testimony.

TESTIMONY OF RONALD L. FLETCHER, M.D., DIRECTOR, OHIO DEPARTMENT OF HEALTH, COLUMBUS, OH

Dr. FLETCHER. Senator Glenn and members of the staff and Committee, I am pleased to be with you today to address the important issues of alcoholism recovery and treatment services. As director of the Ohio Department of Health, I would like to share some of our successes and then take some time to talk about alcoholism treatment needs in a broader scope. While aggressively promoting prevention, we must recognize that those people dependent on alcohol deserve an opportunity to recover.

In Ohio, the Bureau of Alcohol Abuse and Alcoholism Recovery is housed within the Ohio Department of Health. The State Bureau on Drug Abuse falls under the jurisdiction of the Ohio Department of Mental Health. Both agencies come together under one bureau chief. Working under the Bureau of Alcohol Abuse and Alcoholism Recovery, 12 regional councils on alcoholism have the primary responsibility for planning treatment and prevention services within their respective geographic areas. Their services encompass all of Ohio's 88 counties. More than 600 local programs working through the regional councils provide alcoholism treatment and prevention services to Ohio citizens.

Ohio was the first State to hold a statewide organizational meeting for the "Just Say No" clubs. Ohio teenagers also have the opportunity to attend the Ohio Teenage Institute, which is designed to prevent alcohol and drug abuse among youths through personal development and peer intervention. We have 75 certified driver intervention programs operating in our State.

Recently, the Ohio Department of Health received a 2-year grant for the High Risk Youth Project. Its purpose is to deliver coordinated community services to address not only youths who are at high risk for drug and alcohol abuse, but also their families. As you can see, Ohio is striving to meet the needs of those suffering from alcoholism. We are making an impact, but that is not enough. We must commit ourselves to solving the problems.

I think one way to do this is to stop the glamorization of alcohol by banning all forms of alcoholic advertising. The reason I feel this strongly is because the alcohol industry spends over $2 billion a year on advertising, and this does not include all of the promotional campaigns. Yet, alcohol consumption causes 100,000 deaths and results in over $120 billion in economic costs to our Nation each year.

These ads have a harmful impact on our children because they never show the negative effect of alcohol. Kids in America view over 100,000 beer TV commercials before they are of legal age to drink and drive, and even with anti-drunk driving campaigns, alcohol-related traffic deaths remain the number one cause of death for 16- to 24-year-olds.

There is also a big push by the alcohol industry toward minorities. Beers with higher percentages of alcohol are marketed almost exclusively to blacks. In general, there are many more alcohol advertisements in black-targeted magazines than those geared toward the general population.

The alcohol beverage industry has voluntary guidelines about advertising, but this is not enough. Subtle violations occur all too frequently. The Federal Government must either ban advertising or agree to provide an equal time for public service announcements which will educate consumers on the harmful effects of alcohol consumption. Only through education can we begin prevention. In the meantime, though, we have to help those who have already fallen on to the difficulties of the disease through treatment programs.

Let's take a moment to look at some of the demographics, which will show us how we can allocate funds to best meet these clients' needs. Fifty-seven percent of Ohioans admitted to publicly-funded Ohio Department of Health treatment programs are between the ages of 25 and 44 years. There has been an increase in the number of females entering the treatment, as well as an increase in the number of blacks and Hispanics. However, the percentage of those in treatment who are employed and the percentage of those who have insurance has decreased.

Therefore, we are in fact seeing an increasingly medically indigent population in our treatment programs. But medically indigent, I mean those living below the poverty level and/or without adequate health care insurance. More than 177,000 medically indigent Ohioans need treatment for alcohol problems but only 18,000 to 20,000 are treated each year.

One of the reasons for this trend is that our insurance system fails to provide adequate coverage for this disease. For instance, Medicaid does not pay for appropriate residential rehabilitation care for adults, even when it is needed, resulting in greater human misery and higher costs in the long run. Day and evening programs lasting 5 to 6 hours allow the patient to stay in his community and continue to work. These have proven effective, but many insurance companies do not recognize that level of care.

Only a little over $18 million was used in fiscal year 1987 for treatment of the medically indigent in Ohio. Of this amount, $15.5 million was contributed by the State, local or other sources, and $2.5 million from the Federal Government. According to the Bureau of Alcohol Abuse and Alcoholism Recovery, an additional $80 million is needed to adequately treat this segment of the population. With very conservative estimates, the Federal Government should contribute an extra $11 million in treatment funds for Ohio's medically indigent. However, the State and its local communities would then have the responsibility of contributing over $69 million.

Another population that is often included in the medically indigent is women. In Ohio, 5 percent of the Federal Block Grant is set-aside to be used specifically and solely for women's treatment programs. We now have 36 treatment recovery programs statewide. Special services include residential treatment for women and their children, daycare services for women, adolescent women's treatment services, and curriculum for middle schools regarding family problems, substance abuse, and eating disorders.

While it is important that special populations receive services targeted towards their specific needs, we should not tap dollars from existing programs. Established programs would be jeopardized when taking their resources to create set-asides. Instead, new dollars must be earmarked for special populations because as with any disease, people experience alcoholism differently. To be effective, treatment should reflect those different experiences. If block funding were increased, there are many other groups whose needs could be more adequately addressed.

For example, children of alcoholics have a 25 to 50 percent chance of becoming alcoholics themselves. They are also at highest risk for marrying someone who becomes an alcoholic. Children of alcoholics are frequently victims of incest, child neglect, and other forms of violence and exploitation. They, too, are prone to a range of psychologic difficulties, including learning disabilities, anxieties, attempted and completed suicide, eating disorders, and compulsive achieving.

After consulting with various counselors in minority centers, we have concluded that another gap exists within minorities. Although they are currently served by our system, to treat minorities effectively, we must have programs that will address recovery in a culturally sensitive manner. Treatment must reflect a person's values, beliefs, family dynamics and problem-solving styles. For example, the use of storytelling, mentoring, and visual learning tools has been found very helpful in black recovery programs. Adequate funding will enable a more creative approach to treatment above and beyond the traditional cognitive style. The problem is multifaceted and the treatment options must reflect that.

Alcoholism accounts for high losses in the Nation's revenue. Annually, the United States loses more than $116 billion and Ohio over $5 billion in alcohol-related costs. These losses stem from treatment and support services, mortality, reduced productivity, lost employment, motor vehicle crashes, crime, and social welfare problems, among others. We must recognize that proper funding for treatment will stop the compounding effect of alcoholism on our society and put an end to the vicious cycle it has created.

While the use of alcohol appears to be generally declining or stabilized, its use and abuse still present enormous problems. Ohio has an estimated 527,000 adult problem drinkers. The capacity of adult alcoholism treatment facilities will need to increase because the age bracket of 25 to 44 years, which accounts for most of the current patients, is predicted to increase by 7 percent by 1995. There are believed to be up to one million children of alcoholics in Ohio. One-quarter to one-half of them either are or will become alcoholics themselves.

This ongoing cost in lives and dollars will occur year after year until we eliminate the problem through preventive strategies. While continuing to design flexible treatment programs and providing adequate funds, we must make a determined effort toward prevention. We do not want to merely treat alcoholism, we want to put an end to excessive alcohol consumption, the number 1 legal drug problem in the United States.

I thank you.

Chairman **Glenn**. Thank you very much. You have some very interesting figures there on our programs. That one figure of 527,000 problem drinkers, that would come out to about 5 percent of our total population.

Dr. **Fletcher**. Yes, sir.

Chairman **Glenn**. One out of every 20 people you pass walking down the street would have some major alcohol problem.

Dr. **Fletcher**. Yes, and that includes age groups from 13 on up.

Chairman **Glenn**. Ms. Deborah Beck, President, Drug and Alcohol Services Providers Organization of Pennsylvania out of Harrisburg.

Ms. Beck, we welcome you this morning and look forward to your statement.

TESTIMONY OF DEBORAH BECK, DRUG AND ALCOHOL SERVICES PROVIDERS ORGANIZATION OF PENNSYLVANIA, HARRISBURG, PA

Ms. **Beck**. I am sort of wrenching around here because my feet do not quite touch the ground. I want to apologize for not having a written statement in ahead of time. I will send it after the fact. My chicken scratch did not get to my staff on time.

I also want to apologize to the steno before I get started. He will know what I mean in a minute. I feel a lot of urgency around this issue and I think that will become apparent and I get moving very rapidly.

Earlier in the morning there was some discussion of doing case management and matching patient need to level of care. I just want to start by noting that we know how to do that but it becomes a kind of cynical discussion if we get hung up on that issue when in fact the continuum of services are just plain not available.

And I have seen that discussion around case management and let's try to place the patient at the right level of care when in fact those levels of care are not available, and I hope we will look at some of the resource issues first.

Thank you for the opportunity to testify this morning, and I confess to being a little nervous. In fact, I am lying to you. It is not butterflies this morning; it is more like eagles. I have been nervous a lot recently because as I move around, I have been being asked a lot of questions and the questions are like this: "How are we doing on this war on drugs?"

And by way of apology, I guess, I want to warn you that I am a treatment clinician, which means I am not a diplomat, and I have been a treatment clinician since about 1971. Part of that experience includes running and managing and doing treatment in a skid-row drug and alcohol program.

I guess what I am trying to say is I am probably going to step on somebody's toes, and since I cannot avoid that, I might as well aspire to it and become an equal opportunity offender. I suspect I am doing my job if that happens.

There is absolutely nothing in my job description that relates to pulling punches on the drug and alcohol problem. In fact, just the opposite. My professional career and that of my colleagues has been dedicated to breaking down the walls of denial and misunderstanding that typically surrounds this issue.

We are attuned to the denial of the individual, but denial and misunderstanding is a bigger problem than that. It impacts on families and communities and the culture in general, and we are also concerned about the permutations of misunderstanding of the alcohol and other drug problem on the formation of public policy on both the State and the local level.

In 1986, I have got to tell you, it was a banner year for drug and alcohol. The liberal voice, the liberal *Newsweek* magazine discovered we have a drug problem in the United States, and we were glad to see that. They decided to cover it weekly, they said in their lead-off article, like they had the war in Vietnam, because it was so important.

Also in 1986—in fact, earlier—President Ronald Reagan discovered that there is a drug problem in America. Now, we are very grateful to have these two disparate opinion setters make this important discovery, and we are very glad for the public support and focus. But they share another perspective as well, which is very unfortunate, and I think needs to be addressed. These opinion makers and others—and I understand that this is a politically charged issue—but these opinion makers, neither of them want to use the "A" word, and I am talking about alcoholism, and I am talking about alcohol abuse. And I think that that is very unfortunate.

Neither wants to talk about the leading killer drug in the United States, and we must ask ourselves who does this perspective serve? Who does this status quo perspective serve? Why is it we cannot address this issue? Some very troubling thoughts come to mind, but I think we have to look at it.

Who does this perspective serve? Certainly not the children. Certainly not the children in the United States, because despite what you read and see and hear, the leading killer drug of young people in the United States is alcohol, always has been, probably always will be. The life expectancy of the age group 15 to 24 has dropped to where it was 20 years ago, predominantly because of alcohol related problems, accidents and car fatalities.

As was mentioned earlier, this is also the leading killer of American adults, and we will lose 100,000 Americans this year, and I have got to ask, why is that acceptable when other forms of deaths are not acceptable in the United States? That raises some troubling questions. Who does the status quo serve?

Alcohol is a gateway drug to other drugs. I have never met a heroin addict who was not addicted to booze first. Now, somebody will find one, I am sure, after the hearing, and run that person out. But, I mean, somewhere there has got to be one. But it is important to know that alcohol is the gateway drug.

Some statistics that impact on children: 50 percent of domestic violence, child abuse and incest—untreated alcoholic in the home; 50 percent of preventable birth defects—think of the heartache here, but also the economic impact—untreated alcoholism or alcohol abuse. One in four children today is born in the home of an untreated alcoholic with a genetic predisposition toward the disease, and then on top of that, there are a host of other problems. In fact, statistically, one in every four of us here today is the adult child of an alcoholic and you know exactly what I am talking about when I talk about the other related problems.

We lose 8,000 teenagers every year to drunk driving fatalities; we injure 40,000. Children run away from home. Large numbers are using drugs and alcohol, but also a number of those children running away from home are running away from drug and alcohol abuse, domestic violence, child abuse and incest in the home and running away may be a sign of health for that percentage.

It is not an accident that the teen suicide rate appears to be raising at the same time that the average age of first use of drugs and alcohol is going down. That is not an accident. There is a correlation there. I have seen some research that indicates that 70,000 of successful teen suicides—that is a kind of strange way to refer to successful teen suicides—either there was an untreated alcoholic or addict in the home—mostly alcoholic—or the young person was using drugs and alcohol. You combine that with adolescent craziness and of course the child is suicidal.

The failure to persistently address the "A" word I think is an example of our cultural misunderstanding of the alcohol and other drug problem in the culture. And I also have got to say, this is not an ideologic problem and this misunderstanding, nor the understanding of the problem does not bear a partisan stripe.

Recently we have set out nationally to stamp out crack, and I am glad for that. Nothing wrong with that. Americans are educable. In fact, the media campaigns of the 1960s and 1970s greatly reduced the utilization of LSD and PCP. But let's not forget that alcohol is our leading drug problem. Our number 2 drug problem in the United States is prescription drugs, the addictive sort that are legally obtained. We are not even counting that one. Number 3, prescription medications diverted. Dead last is the illicit drug traffic. But we go at it in inverse order when we start to look at policy, and that scares me. I am not putting down the illicit drug problem.

It is tremendously serious. But we have got to look at the whole thing.

One of my colleagues is also fond of pointing out that we have lived through at least three wars on drugs. It is important to note that there will always be another drug, a new acronym drug, coming along the corner. There is an alphabet soup of them out there. There will always be another drug to address, and we can keep launching special campaigns, but we have to stop letting the infrastructure and the routine business of prevention, education and treatment deteriorate in the meantime.

How have we been doing on the war on drugs? Will the new war on drugs initiative fix the problem? Let me frame it this way. The annual cost of alcohol abuse alone to the culture is estimated at $120 billion annually renewable and that is the price tag of denial that we are going to pay until we get serious about this problem.

Pennsylvania's share is $8 billion; $8 billion is the price tag of denial. In Pennsylvania we spend less than 1 percent of that amount on prevention, education and treatment every year. And we are a State that has struggled very much to offset Federal cuts. I think the Pennsylvania legislature and the Governors have tried to be terrible responsible. But Pennsylvania's dilemma is not unlike that of other States. In the last 5 to 8 years the Federal cuts to the war on drugs going into the States, the Federal monies, plus inflation have resulted in about a 45 percent cut in funds going into States. What does that mean, bringing it right down to the grassroots? It means people in your community cannot get treatment for a disease that will kill them. And it is important to note that addiction to drugs and alcohol is a progressive, always fatal illness if it allowed to go unchecked.

When I first began to do advocacy, believe it or not, someone said to me, well that is one way to fix the problem. If it is a fatal disease, it will get rid of itself. After getting over my shock, the person went on to say, they made their bed, let them lie in it. And I said, we share that bed. No alcoholic or addict dies in isolation. He or she will impact on six to eight others in the immediate environment. It will be emotional. I will be fiscal. And it is not a matter of will we pay for this problem; it is a matter of when will we pay for this problem, at what juncture. At what juncture of pain in the culture will we start to do intervention and do something about it.

I will impact on my mother, father, sister, brother, co-worker. I may run over you in my car. You may pay for it through the insurance premiums. But pay for it you will.

We are fighting a war without bullets. We have waiting lists. Will the Federal anti-drug money solve the problem? The answer in a nutshell is no. Pennsylvania has a $17 million hole in its war on drugs. We got $8 million in emergency treatment money, and then we were told that that was to be spent over 2 years. And we are deeply grateful for those dollars, but that works out, if you divide it across Pennsylvania counties, to about 12 to 15 more people per year getting service. And I beg that much free service off the programs in my State quarterly. Programs give away free services. We have counselors who are eligible for food stamps and we are still not keeping up with the demand.

What about the Federal Block Grant Program? In Pennsylvania, prior to the Federal Block Grant Program we got $4 million in direct grants to programs. Those dollars were eliminated. Those dollars were eliminated when the Federal Block Grants were created and the Block Grant structure also seemed to me to disguise reductions in funds coming into the State. And we were so busy getting used to the change in structure that we did not notice for a while, but the fact is, we lost $4 million off the top plus changing and getting used to the new structure involved phasing in some cutbacks.

I know that the goal of the Block Grants was to give the single State authorities more local control. Well, they got more local control all right, and they also got stuck explaining why programs were being reduced on the local level. They got local control and local blame.

What I see us doing is in response to the latest new drug—I have seen us do it over and over again since 1971—we have a habit of moving things around and shifting the structure. We get busy rearranging the deck chairs on the *Titanic* when the ocean liner is in fact being allowed to deteriorate. And I think we have got to stop rearranging the chairs and passing out new acronyms, and we match bureaucratically—we match the acronyms for the drugs, acronym for acronym with new agencies, new procedures.

Down at the program level what does that mean? And I speak case data. A pregnant cocaine addict gets turned away from treatment. An IV drug user gets turned away from treatment, and a mother desperate for treatment for her son cannot get her son in the doors.

Another note of caution. When I hear proposals that want to separate drug and alcohol authorities and plans, I get very nervous. I am not sure that it is not another example of cultural misunderstanding at work, or even perhaps denial. I live in a State where the drug and alcohol authority is combined. That is logical and saves money from an administrative perspective, but what is important to me is it saves money from a clinical perspective.

We do not see pure alcoholics, and we do not see pure drug addicts. I am not sure we ever did. I am not sure such a phenomena ever existed. I am sure there are some somewhere. What is happening is your drug and alcohol folks in States where the authorities are separate have to try to make a decision on how do I register this person is front of me? As a drug addict or as an alcoholic? When in fact they are addicted to both. Or if they switch substances, you are going to discovered that they are addicted to both. It is a strange discussion.

One thing the Block Grant proposals did do is they did concentrate authority in a single State authority, and I think that is a good idea. But then the anti-drug law came along and set about diffusing that authority again. And, again, I am talking about rearranging deck chairs on the *Titanic*.

What happened? I will just give you one example. The departments of education were given sizeable amounts of prevention education money. I have no problem with that. But it is not education's job to stay state-of-the-art in drug and alcohol. It is a full time job for me.

We are making out all right in Pennsylvania because the gentleman who heads the Department of Education is sensitive to the problem. But what would have happened if he was not, or if she was not? We would be having some difficulties.

We need to be careful not to mistake activity for effectiveness. It makes us feel great that we have done something. We tend to look for quick-fix, sensationalistic solutions like seal off the borders, put walls around the United States and shoot down the planes. I am not anti-law enforcement. It makes common sense to limit the availability of some of these drugs. But while we are building walls, we forget to look at the enemy within. It is far easier to identify an enemy outside and point fingers, and here we are with our guns, and my cartoon fantasy is the soldiers with the guns on the border with a marijuana plant growing behind their backs.

It is important you know, we make synthetic heroin in United States. We make synthetic illicit drugs. And if we do seal off the borders, we are going to have a wonderful local industry on the making of illicit drugs. We have got to limit access, yes; but we have got to do prevention and treatment.

Again, beware of quick-fix solutions, short term, "feel good," "junk food" solutions to this problem. It is reminiscent of the mindset that got us into the chemotherapeutic society in the first place. Instant highs, instant cures, immediate gratification, fast food solutions is not the way to address it.

We keep kidding ourselves. We keep pretending we do not know what to do about the problem. Well, I would like to submit we know exactly what to do about the problem. And there is no magic to it. There is simply no substitute for the drudge work of prevention, education and treatment done in a thorough and comprehensive way. And for those who say it does not work, we have never tried it. We have never tried it.

Two examples of technological quick fix. Just two short examples. We want to get touch on pushers, lock them up. Well, that is certainly the salutary goal. But what do we mean by pushers? The number 1, pushers of drugs and alcohol on young people today in America are parents. Is that who we are going to lock up? That is not who those laws are set up for.

The number 2 leading drug pusher is other kids. Other kids emptying mom's medicine cabinet or getting some stuff and sharing it or selling it. Those are the leading drug pushers in the United States. You would not know that by looking at the direction we are going.

The number 3 drug pusher is statistically not that big. He or she is still a problem, of course. Over 80 percent of drug pushers who manage to get locked up are already addicted to drugs and alcohol; i.e., they got sloppy and they got caught and the person making the millions of dollars on the drug deal did not get caught. Well, what does that mean? So let's lock up that number 3 and ignore 1 and 2. That is what we are doing.

Let's lock up number 3, but then if you do not treat my addiction and I come back to the street, I am going to sell drugs to your kids anyway. And we have got to do treatment. We have got to do treatment if we are serious about getting tough on drug pushers.

The next piece of technological quick fix that worries me is the idea that if we get everybody—I have got to keep from speaking too bluntly here, this is a formal hearing—it is what I refer to as the "urine utopia" solution to the drug problem in the United States. I have seen an enormous number of proposals, have gotten calls from a number of businessmen who are really scared and they want to institute mass urine screening.

Of course, no one is going to test for alcohol which, of course, they would find. But maybe that has something to do with what we are about here, I am not sure.

There is a role for drug screening. I do not want to put it down. Please hear me. But it is a limited role. Our facilities use drug screening, but we also understand implicitly its limitations. "Urine utopia" is not going to do it by itself. Junkies who are not deteriorated know how to get around a drug screen, and you are going to have to do some things that come severely close to terribly violating civil liberties, that is, watching the obtaining of the sample to avoid having the junkie clean up a sample.

Now, you will catch some junkies, you bet, and drug users; those who are too deteriorated to begin to take precautions to make sure they are not caught. But you probably could have spotted them with proper supervision in the first place. So it is an interesting kind of solution. What we are afraid of is that we will grab for a solution like that and forget about prevention, education and treatment.

There is a role for this, absolutely. I know in some businesses this is referred to as specimen management. I understand there is this idea that we are going to put blue dye in the toilet bowls and have people hired to be in the stall next to the person. This is wonderful. We have an unemployment problem in one part of our State. I was thinking this would be a great new civil service category: Specimen Management 101.

What has happened is there is already a very good black market. In direct response to what has been called in the media "Jar Wars," there is a black market on clean urine. There is black market on clean urine. Well, we have funding problems in Pennsylvania in the drug and alcohol program. I know that my staff is all clean. We could sell our urine for a half ounce, $49.99—it was advertised in a magazine—and we could take care of our funding deficit back there. You see the problem we are addressing.

Very quickly, prevention, education and treatment is humanitarian for sure. But we also have got to look at some fiscal constraints. I know you are operating under tremendous fiscal constraint. And so let's can the humanitarian clap-trap and let's get down to the taxpayers' money and where we shall spend the taxpayers' dollars. Shall we spend it on health care? Untreated alcoholics and addicts use health care 10 to 12 times more per year than the general public; 30 to 60 percent of daily admissions to hospitals are alcohol-related.

Where shall we spend the taxpayers' money? Shall we spend it on building prisons? Seventy percent of people in prisons have untreated drug and alcohol problems, and when I come out I am going to resume my crime unless you do treatment. Shall we spend our money on building new prisons?

What about on welfare? I have read one proposal after the other that cites welfare reform. I have not seen one yet—and I may be mistaken about that—that decides to do drug and alcohol care of alcoholism treatment as part of welfare reform. Medical assistance will pay for revolving door detox and some outpatient services, but for the most part it will not pay for needed inpatient rehabilitation services. There is a tremendous barrier to care. This is also a woman's issue, I have got to tell you, because women with dependent children cannot get rehab, a very, very important issue.

Thirty percent of people on welfare are believed to be there with an untreated drug or alcohol addiction, primarily alcohol. Are we serious about getting people back to work? About cutting down on health care? Or are we going to pour job training money over somebody who cannot benefit by it until the addiction is treated? And by the way, recovering alcoholics and addicts make the best employees you could possibly find.

Fifty percent of the homeless, 30 to 60 percent depending on whose statistics you want to look at, are untreated alcoholics or addicts. Do we shelter them, warehouse them, so they recycle through the warehousing? Or do we provide treatment?

Where shall we spend the taxpayers' money? On fetal alcohol syndrome? Fetal drug syndrome? 1.5 million a year for people already born with fetal alcohol syndrome.

What about drunk driving insurance premiums? It goes on and on. How about AIDS? The financial consequences of AIDS, when we cannot provide treatment on demand for IV drug users. Where shall we spend the taxpayers' money?

What can we do? I think we need to avoid technological quick-fix, number 1. Number 2, we have got to stop rearranging the deck chairs, because even if the deck is not perfectly arranged, every time you shift it on the Federal level we get mixed on the local and we lose ground.

We need to provide resources. The ups and downs of Federal money has made it very hard to do good management on the local level and then we get blamed for poor management.

Specifics: medical assistance needs to begin to provide some Federal matching money for inpatient rehabilitation services. Right now there is an incentive match there for detox and outpatient. We need the array. The bizarrity is, I can use my welfare check to buy drugs but I cannot use my MA card to buy the continuum of services that are needed. And I think that is a very interesting statement of where our priorities are.

The national health insurance law that has been proposed. I understand the intent, and the intent is very positive, I believe. However, the number three leading disease killer, alcoholism, is excluded from that matrix. And worse yet, that law would eliminate preexisting State laws. Pennsylvania has a mandated alcohol insurance bill. We would lose that law, that locally tailored law. We would like to ask that that provision of the National Health Insurance Bill be removed to allow States and local authorities to develop their own mandated insurance laws. And in fact, if you want to mandate something, maybe mandate that States shall deal with this.

Thirty-seven States have already passed laws. We will lose them the way the bill is presently drafted. It seems inconsistent to state that that is your health goal and then take away services for alcoholism and drug addiction on the local level.

I am paging because I have signs here that say, "slow down, you talk too fast."

I want to end by saying simply this. Today, tonight, a drug and alcohol counselor down the street and in your community is being forced to play God. He or she is choosing who to admit and who to turn away. Tonight I will go home and on my answering machine I will hear from people who are begging to get into services and we will not be able to place them. I was in that position one day. I had a mother I had never met crying, begging me for services for her son who was ready to go, and in the background I heard on the radio the slogan campaign, "Just Say No." Well, I just said no, all right. I could not get him into services.

We say just say no and when people start turning out for help, then we cannot help them. It is not enough. A slogan campaign is not going to impact at that level. A slogan campaign is a useful focus nationally, but not at that level.

I thank you very much for you time. I thank you for your attention to this issue.

Chairman GLENN. Thank you, Ms. Beck. You make a very persuasive case.

Let me ask all of you, do you feel that on the Federal programs, now we got away from categorical grant programs, those targeted at the specific areas. We went to the general Block Grant programs and left much more up to the States.

Do we have a problem in Ohio, for instance, in getting the money out of the Block Grant Program?

Dr. FLETCHER. Well, the Block Grant concept, again, conceptually it sounded like a pretty good idea. The problem is——

Chairman GLENN. It leaves the States flexible to do what they think fits their needs best.

Dr. FLETCHER. Well, in fact, not as we would like it to be. You now see what we have are categorical requirements for the Block Grant, which is a subtle way of putting us back into categorical. In other words, in order to get the Block Grant money you have to specify certain areas of utilization for that Block Grant money and, therefore, giving the State less latitude to use the resources.

Chairman GLENN. Well should we be going back into categorical then so we make sure the money gets spent, at least part of it, for what it was intended?

Dr. FLETCHER. I think the preventive Block Grant has given us the opportunity to do a number of things. It is the restrictions that are placed on this by this categorical requirement that makes it a difficult circumstance.

Chairman GLENN. Mr. Lubben, could you discuss the role that Medicaid and Medicare play in funding alcoholism treatment? For instance, the new rule which will be effective July 1st permits Medicare reimbursement for alcohol treatment by clinical psychologists. Is that going to provide increased access for indigent clients and so on? What is the trend there?

Mr. **Lubben**. It is difficult to predict what the impact of that would be. I believe it would be an improvement in that it provides a new group of professional service providers which the Medicare client would have access to. Our concern is that we believe that it is important for alcoholics and drug addicts who have Medicare as well as Medicaid have access to professionals who are specifically credentialed in alcoholism and drug abuse services. And we would support making available direct reimbursement through certified alcoholism and drug abuse counselors for that population.

Chairman **Glenn**. I am sorry we do have another panel yet to go here this morning. We may submit some additional questions to you for you to answer, but unfortunately we are going to have to move along here. I hope you will bear with us on that and can get the answers back in so we can include that in the Committee record.

We appreciate your being here this morning. I am sorry we had to delay things a little with the vote over there, but we are doing the best we can with this.

Thank you all very, very much for being here this morning.

Our next panel, and the last panel, is on access to care. We will hear from Ms. Brenda Underhill, Executive Director, Alcoholism Center for Women of Los Angeles; and Dr. John Jackson, Administrator, Alcohol and Abuse Services Administration, Washington, D.C.

Ms. Underhill, Dr. Jackson, we welcome you to the hearing this morning and we look forward to your testimony.

Ms. Underhill, will you lead off please.

TESTIMONY OF BRENDA L. UNDERHILL, EXECUTIVE DIRECTOR, ALCOHOLISM CENTER FOR WOMEN, LOS ANGELES, CA [1]

Ms. **Underhill**. Thank you Senator Glenn and members of the Committee and staff. My name is Brenda Underhill and I am the Executive Director of the Alcoholism Center for Women in Los Angeles, and although my past 8 years of experience at the Alcoholism Center for Women has been focused on working with women alcoholics and women at high risk of developing alcohol problems, my previous work from 1975 to 1980 was primarily with indigent alcoholic men and teenagers with alcohol problems.

I welcome this opportunity to address your Committee on the alcoholism service needs of women and other under-served populations and the role of the Federal Government in assuring equitable, accessible and effective services to these populations. Before discussing the specifics of alcoholism treatment for women and underserved populations, however, I would like to stress that alcoholism is a deadly and costly disease for the individual, the family and our society. Alcoholism is a primary disease. It is not a symptom of a psychological, underlying disorder, an indication of moral weakness or willful misconduct. It is physically, emotionally, cognitively and spiritually progressive and degenerative and can be arrested only through abstinence from all mood-altering drugs.

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[1] See p. 204 for Ms. Underhill's prepared statement.

And it is fatal if it is not arrested through abstinence. It is characterized by relapse, which is a return to drinking, particularly during stressful times.

Finally, alcoholism affects all members of the family and all such members need availability of effective services. The emotional costs to the individual are high in our society. A minimum of four to six individuals are intimately affected by the association of one alcoholic, and one-third of all families in America report that alcohol abuse is a serious problem in their family.

Unfortunately, illicit drug use and trafficking produce a much more comfortable focus for most citizens, as illicit drugs are not, as a rule, served with the family dinner, advertised in the media, or used to salute heads of state.

Having outlined some of the underlying fundamentals of the disease which apply to all alcoholics, I would like to focus the rest of my testimony on the issues confronting women and other underserved populations in obtaining accessible and effective alcoholism treatment services, and then on the role of the Federal Government in addressing these issues.

The first point I would like to underscore is the importance of shifting the conceptualization and specific designation of women and minorities to the use of the term "under-served" and not "special." To some, this may appear on the surface to be a semantic argument. I submit, however, it is not.

The difference in terminology is pivotal to providing accessible and effective services to the populations under question. Using the word "special" has the direct impact of placing the problem on the individual or supposed minority. It implies that the difficulty in working with such groups lies with the peculiarities of the group or groups in question, rather than simply acknowledging that the life experiences of these groups is different than the life experiences of the alcoholic population that has been most heavily researched and documented, which is the white heterosexual male, who is free of physical disabilities.

"Underserved," on the other hand, is a term which is descriptive of the truth of the situation. The literal definition of this term is less than the required amount or degree to meet the existing needs.

We know alcoholism occurs in all populations. It is often billed as an equal opportunity destroyer, yet statistically women and other underserved populations are not equally represented in treatment services or research.

For example, many leaders in the field of alcoholism often state that they believe that 50 percent of the alcoholic population is female, but among nationally and publicly-funded programs, women comprise only 24.6 percent of those served. We must focus our examination then on the systemic and institutional barriers that underserved populations encounter in the alcohol service delivery system.

The terms "underserved" and "under-represented" keep us in that framework which is essential if we are to take appropriate corrective actions to assure equal access to quality alcoholism care.

Time limitations today make it impossible for me to only begin to touch on the pertinent issues of underserved populations. The common denominators, however, shared by these populations are higher stigmatization, minimal targeted outreach, a serious deficiency in research focused on these populations, lack of effective and accessible services, and services providers' lack of knowledge and biases where these populations are concerned.

Also, when examining the barriers that women and other underserved populations experience, financial resources and the lack of financial resources must be emphasized. These groups as a rule have limited financial resources, including access to third-party reinforcement for alcoholism treatment.

Ninety percent of all women who have been admitted to the Alcoholism Center for Women's Residential Program are at or below the poverty level. Approximately 55 percent of them have no address at time of admission. Poverty pockets in our cities tend to be comprised of non-Anglo residents. This lack of financial ability to access health care systems clearly demonstrates why public funds must be equitably allocated to alcoholism treatment services for women and people of color.

Many publicly funded programs are tempted by the income of insurance reimbursement to adapt their services to insured clients, thus further reducing services for the poor and the working poor.

Historically, alcoholism services and self-help recovery groups were and continue to be based on a white male model. While it is true that alcoholism does not discriminate in terms of its victims, unconscious bias in this white male model does result in services being less accessible and effective for populations other than white heterosexual males, thus creating effective service delivery barriers for women and other underserved populations.

Some of these barriers include failure to acknowledge and account programmatically for the differences in sub-groups of alcoholics. Unfortunately, most treatment programs perpetuate and reinforce the myth that "an alcoholic is an alcoholic is an alcoholic." A key component to all treatment programs is education about alcoholism. Few alcoholism curricula include such information for women and other under-served populations.

An example of this is the fact that women's alcoholism tends to progress much more rapidly than men's; that is, it has a "telescoped effect." Alcoholic women show much higher rates of mortality from cirrhosis, circulatory disorders, suicide, accidents, and digestive disorders than do male alcoholics.

Women in treatment with shorter drinking histories are too frequently told by their male counterparts in group, "Honey, I've spilled more than you've drank." Since peer feedback is core to recovery, this type of statement only furthers a woman's denial of the seriousness of her alcohol problems.

Additionally, cirrhosis causes approximately twice the number of deaths in the black community as in the white community. Alcoholic cirrhosis causes the death of one in four Native American women. This rate is 37 times that of their white counterparts.

Secondly, our society has a double standard for male and female drinkers, and women who are alcoholic suffer greater social stigma than do male alcoholics. Greater stigma leads to greater denial and isolation. Additionally, providers have been shown to view the woman alcoholic as less motivated, more pathological, and more difficult to serve than men.

Third, outreach methods are seldom targeted to specific groups. Many providers feel in order to serve diverse populations, all that they need to do is open their doors.

Fourth, only a handful of treatment programs nationally provide child care services. Therefore, if a woman with children seeks services, she must literally choose between her recovery [her life] and her children. Many alcoholism treatment programs either fail to or refuse to deal with the issues related to sexual abuse. It is estimated that between 40 to 70 percent of alcoholic women have been sexually abused. While this issue cannot become the primary focus of early recovery, the abuse needs to be acknowledged in a safe environment.

Sixth, research in the field of alcoholism continues to exclude a statistically significant percentage of underserved populations. Women in particular are under-researched. The overwhelming majority of research studies are conducted on males, and even more specifically, those males are often veterans.

Exacerbating the problem in research is researchers' continued generalization of the results of their studies to all populations. It is one thing to not have specific research information, but this generalization of results perpetuates a generic, non-targeted, approach to recovery.

Seventh, vocational training for women and indigent men is haphazard at best, and does not take into consideration the disenfranchisement that these populations have experienced in the workforce.

Eight, a negligible percentage of treatment programs provide adequate bilingual services, and even fewer programs make an effort to provide not only bilingual, but bicultural services.

America is a diverse and rich Nation. Our alcoholism services programs need to reflect that diversity. Not only do we have a moral obligation to provide publicly funded programs for all people who suffer from the devastating effects of alcoholism, a targeted population approach is also very cost-effective. Over 13 years of experience at my program has demonstrated that services designed for stigmatized groups are effective for more "mainstream" groups, what I refer to as a "trickle-up effect," but the reverse dynamic is not true. And now this experience is finally being empirically documented through research.

Thus, I return to my original points: women and other underserved populations are not "special" groups whose concerns we cannot afford to address in economically difficult times. Working with the most stigmatized groups further advances our knowledge of providing effective services to all alcoholics.

If we, as a nation, are to adequately address the alcohol problems of women and other underserved populations, it is extremely important that the Federal Government take leadership. The National Institute of Alcoholic Abuse and Alcoholism was an example of such leadership. The direct grant program of NIAAA resulted in many innovative and effective programs for women and other underserved populations.

My own program, the Alcoholism Center for Women, is such an example. Opened in 1974, with an initial 6 years of Federal funding, we have become the largest comprehensive publicly funded nonprofit women's alcoholism recovery and prevention services program in the Nation.

However, with the changes to NIAAA in 1981, the Institute's role in treatment was transferred. Funding for treatment was reduced by 40 percent. ACW had the benefit of 6 years in which to establish ourself and broaden our funding base, and we were able to integrate into the local planning process.

Many NIAAA programs were not as fortunate as we were, and did not have as much time, nor were they able to garner enough community support for services to their target populations, and they were forced to close their doors.

In addition, NIAAA's much-needed data system was lost. Federal treatment standards, a movement in its infancy, was also lost. Research on the psycho-social aspect of alcoholism became a low priority of NIAAA. This type of research is critical to understanding the interplay of the disease of alcoholism and the social realities of people's lives. The lack of this type of research particularly affects underserved populations, since they are the most under-researched.

I am here to say that the loss of NIAAA, and the overall Federal leadership in alcoholism treatment and prevention, has been a severe blow to women and other under-served populations. The belief that local communities would adequately provide for these groups through the block grant program has not proven to be true. Stigmatized groups such as women, people of color, people with disabilities, gays and lesbians, and the aging are not given priorities by local communities.

It is absolutely appropriate for the Federal Government to assess needs, and when gaps in services to specific groups exist, to take leadership in earmarking funds and developing service guidelines for these populations.

Not only does the Federal Government need to create more legislation mandating services to under-served populations similar to the women's set-aside, but it is critical that these funds be at least monitored, if not administered, by the Federal Government.

The community demonstration project for the homeless was a recent example of such leadership. Today, I offer the following recommendations:

An increase in the ADMS block grant funding with specific earmarking of funds for services for women and other under-served populations;

An accountability mechanism which assures that these few funds for alcoholism services not supplant existing service dollars;

The establishment of a new research center on women through NIAAA;

A return to the direct treatment funding by the Federal Government of under-served populations by NIAAA;

NIAAA conferences focused on under-served groups, and the dissemination of information on women and other under-served populations by NIAAA;

Increased efforts to train professionals [gatekeepers] who are likely to come into contact with women and other under-served populations, and who are in an excellent position to do early interventions. Projects which are directed at the cross training of professionals prove to be extremely effective method of training. My program, the Alcoholism Center for Women, did such a project with one of its five set-aside programs called "Double Jeopardy." It trained domestic violence people in alcohol and alcohol people in domestic violence;

Increased funding to NIAAA for a comprehensive national data collection system which provides information on client characteristics, descriptive patterns of the underserved's service utilization, and the identification of high-risk groups;

A Federal focus on alcohol as the "number one" drug problem of our Nation;

A resolution by Congress acknowledging alcoholism as a disease. This would have an enormous impact on decreasing the stigma of alcoholism for all populations;

A continuation of the women's set-aside funds;

The development of the national alcoholism treatment standards which are sensitive to gender, race, ethnicity, culture, age, sexual orientation, and physical disabilities;

The development of programs that provide access to vocational educational services, including counseling, training for women alcoholics and other drug addicts who are returning to the labor force or entering it for the very first time; and, passage of legislation requiring warning labels on all alcoholic beverages.

The first step is to acknowledge the enormity of the price that our Nation pays for the lack of a comprehensive national alcohol policy. The liquor industry profits well from our denial that alcoholism is the third largest public health problem in America.

Your Committee is to be applauded for its work. It is one of the few recent efforts to assess the need for strong national policies in regards to alcohol, alcoholism, alcoholics, and their families. We must, as a nation, continue to ask the questions that need to be asked, and, together, to take up the challenge to change both our vision and our practice. Working together we can reduce the stigma of alcoholism, remove the barriers to treatment, and through sane alcohol policy, reduce the alcohol related problems significantly in our lifetimes.

Thank you for your time.

Chairman GLENN. Thank you very much, Ms. Underhill. It was an excellent statement.

Dr. Jackson, we look forward to your statement. I am sorry you are last on our program this morning. We have run long and we are way over, and I have to leave here at about 12:30. I would appreciate it if you would summarize your remarks. Your entire statement will be included in the record. I am very sorry we have to curtail our time a little bit, but we have some other commitments that I cannot change.

TESTIMONY OF JOHN A. JACKSON, JR., ADMINISTRATOR, ALCOHOL AND DRUG ABUSE SERVICES ADMINISTRATION, COMMISSION OF PUBLIC HEALTH, DEPARTMENT OF HUMAN SERVICES, DISTRICT OF COLUMBIA[1]

Mr. JACKSON. I understand that, Senator.

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[1] See p. 105 for Mr. Jackson's prepared statement.

Chairman GLENN. If you could summarize for us, I would appreciate it.

Mr. JACKSON. I will be as brief as possible. Thank you very much for the opportunity to be here this afternoon. My name is John A. Jackson, Jr., and I am the Administrator for Alcohol and Drug Abuse Services for the city.

Before coming to this position, I spent 25 years in the Air Force, working in the Air Force drug and alcohol programs and family support programs, starting as early as 1969.

Your hearings on alcoholism—and I believe that that focus is at this point very timely—are not just important, but are crucial to carefully consider the effect of alcohol abuse on our population.

The current and understandable emphasis on the war on drugs, I think, may serve to overshadow the significant battles in this war, and that is as a matter of fact relevance of alcoholism.

For the sake of filling in background, please let me just give you a few facts about the organization I operate, the Alcohol and Drug Abuse Services Administration, and some of the problems in the District of Columbia associated with alcoholism.

The District has the dubious distinction of having the highest per capita alcohol consumption in the country. Now, while this figure obviously is skewed by alcohol sales data which include purchases by tourists, commuters and a large international clientele, nevertheless our alcohol problem here is clearly substantial.

The District's State Health Planning Agency estimates that approximately 74,000 residents have a real alcohol problem, with an estimated 14,000 of them being 19 years of age or younger.

Now, in the District, alcohol is considered one of the leading cofactors for accidents, homicides and suicides, as well as a major cause of many health-related deaths. The District leads the Nation in the number of cirrhosis deaths per 100,000 population. Among our young people, a 1986 survey of substance abuse among junior and senior public school students reveals that about 35 percent abstained from alcohol. That is compared to a 54 percent abstention rate in 1980.

Now, some other facts from that survey are kind of revealing. The prevalence of alcohol use among District youth is slightly greater than the national prevalence rates, but consistent pretty much with that of larger cities in the United States.

Another fact: Approximately 67 percent of the District junior and senior high school students have used alcohol at least once. Parents or family were the primary first source of beer or wine use; and, finally, approximately 9.4 percent of the students who use alcohol, drink beer or wine weekly; on a weekly basis, 4.6 percent drink hard liquor every week. Now, the rate of beer and wine use rises from about 33 percent of the 7th graders to 65 percent of the 12th graders. For hard liquor, the rate of use rises from about 14 percent among 7th graders to 34 percent amongst 12th graders.

We in the city provide what we think is a comprehensive system of treatment. It is offered free of charge to residents of the District of Columbia. Now, between our city-operated and our contracted programs, we think we provide a full spectrum of drug and alcohol treatment services at 24 different locations throughout the city. We are capable of treating approximately 4,000 substance abusers at any given time in different modalities.

I want you to know that our programs now are becoming more specifically aimed at youth with poly-drug problems, especially alcohol.

Historically, alcoholics in treatment in D.C. have received a different set of services from those offered by our services for drug addicts. This split is reflected administratively in the two separate bureaus that I operate. I operate a Bureau of Alcohol Treatment Services and a separate Bureau of Drug Treatment Services.

To some degree, that reflects the effect of different municipal and Federal statutes governing treatment modalities for alcoholism and drug addiction, and to some degree it reflects a now diminishing split between pure alcoholics and pure drug addicts. These differences, both bureaucratic and sociomedical, have recently become much more blurred. While the split remains, managerially, ADASA, my agency continued to maintain two separate bureaus at this time, but clinically it is much less meaningful than it once was. We are melding a considerable portion of our actual service delivery and, coincidentally, making better use of our resources, I believe.

It is our observation that cocaine and alcohol mixing clientele are becoming more and more prevalent. These people are able to drink considerably more alcohol, with less apparent adverse effect than if they were drinking alcohol alone. Possibly, this may come about because alcohol obviously is a depressant and cocaine is a stimulant, and the two effects are offsetting one another. But we see a synergism in this new outcome we think bears watching, and we think it has an important implication for the direction of substance abuse treatment and behaviors of substance abusers in the future.

You have indicated that you are interested in how we have responded as poly-drug use has increased. Now, I am delighted to share with you the direction of our planning. We are currently developing a program that in time we intend to demonstrate the idea of matching that was mentioned at one of the earlier panels, as a matter of fact.

We think we have in the city the resources to be able to do a significant assessment and then choose as matching would so dictate. For instance, we have a basic set of three different types of detox available. There is alcohol detox, but we have a detox set-aside for PCP abusers, and still another one for cocaine and heroin abusers.

We can move from that to choices as far as inpatient treatment is concerned, from a 30-day inpatient treatment program that is primarily at this point dedicated to alcohol abusers, to therapeutic communities that last as long as 18 months.

We have a half-way house capability that we think is important to be able to move an individual, to prepare that individual in a working environment and yet have the individual return for the evening to treatment, a treatment environment. We have obviously the largest capability as an outpatient capability and then a follow-up after that.

We believe through that process and, given the choices that we would be able to do effectively the matching, and we tried it and with good assessment, and that is important to do and difficult to do, and continuing assessment with needs and what have you. We think it is possible to do that matching very effectively and very well.

You have asked about treatment for those unable to pay. I have to say that we think we treat first and ask questions later. No treatment is withheld because of an individual's inability to pay in the city. In point of fact, most of our clients do not have the means to pay for the services offered. Occasionally, we do work with third-party payment if we can realize it, but we do operate under the provisions of the Hagan Act, which is Public Law 90-452, which really requires us to offer services free of charge.

On the question of our perception of the need for targeted Federal funds for historically underserved populations, women, the homeless, minorities and the working poor, let me say that we think we help, at least we offer help to each of these groups. Now, obviously it is not enough. I have a waiting list for access to services; nevertheless, we are trying to offer to the full spectrum of those groups that might be identified as underserved.

One of our clinics, as a matter of fact, located on the grounds of D.C. General Hospital, provides treatment services specifically for women substance abusers, with emphasis on women of child-bearing age. There we offer gynecological, pre- and post-natal counseling and support services via contract.

We have a contract with an organization called S.O.M.E., So Others May Eat. This is a mobile substance abuse counseling for the homeless. As a matter of fact, most of our substance abusers in the District are black, our services are therefore aimed specifically at that population as well.

In addition, we have contract programs aimed at serving the particular needs of Hispanics, homosexuals and the hearing impaired. Each of these populations has needs which can best be served in our opinion by making use of existing organizations within that community.

Now, on the question of the working poor, we have found that we have been able to stabilize something like half of our clientele sufficiently for them to be able to work. We encourage our clients to work, and support them in so doing by offering both early and late hours at our clinics.

Finally, I would ask you to consider alcohol abuse in the District in the context of poly-drug abuse. As we pointed out earlier, there are very few alcoholics in the District who are not at the same time substance abusers to a greater or lesser degree of a controlled substance. This means that we must respond to each of these abuse problems if we are to help our patients become sober and drug-free.

We cannot ignore the interrelationship of these addictions if we are to offer successful treatment. So we have had what has historically been a very successful in-patient, half-way house, outpatient program for alcoholics. It is our intention to extend this potential for success to patients who are dependent not only on alcohol but on other substances as well. To do that, I feel I need the flexibility that is provided by the block grant programs, and I would urge and encourage those block grants to be increased, rather than to go to categorical approaches.

I have cut out a lot, Senator, for the sake of time. I hope my testimony has been of help. Thank you.

Chairman GLENN. I appreciate that. I do have other commitments and I am going to have to leave very shortly. I just would ask—and we may submit additional questions to you and we would appreciate an early reply so we can include that in the record also.

What is your waiting period now when someone applies for help?

Mr. JACKSON. It varies, Senator, and let me just give you the various categories. There is no wait for alcohol detox. If there is a bed available, the individual that presents gets it.

For drug detox, our wait is from 4 to 6 weeks. For out-patient treatment, the wait is up to 10 weeks now. For impatient treatment, it depends upon our judgment as to what that inpatient treatment capability requires. For alcoholics, for instance, the wait may be no more than 3 or 4 weeks.

Chairman GLENN. Ms. Underhill, how about your program, how much of a waiting list do you have?

Ms. UNDERHILL. The minimum wait is usually 2 weeks to 4 weeks. We almost always have a waiting list.

Chairman GLENN. The person comes in wanting to take care of their problem, you have to wait as much as a month?

Ms. UNDERHILL. That is also the experience of all the women's programs in Los Angeles County.

Chairman GLENN. I am sorry that our time was short here this morning. There are a lot of questions and we will get those to you. We appreciate your being here this morning and we thank you very much for your testimony.

We will include in the record a statement by Harold T. Yahr, Division of Biometry and Epidemiology, National Institute on Alcohol Abuse and Alcoholism.[1]

The hearing will stand in recess subject to the call of the Chairman.

Thank you.

[Whereupon, at 12:30 p.m., the Committee recessed subject to the call of the Chair.]

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[1] See p. 391.

ALCOHOL ABUSE PREVENTION

TUESDAY, SEPTEMBER 27, 1988

U.S. SENATE,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:05 a.m., in room SD-342, Dirksen Senate Office Building, Hon. John Glenn, Chairman of the Committee, presiding.

Present: Senator Glenn.

OPENING STATEMENT OF CHAIRMAN GLENN

Chairman GLENN. The hearing will be in order.

Good morning and welcome to the fourth of five hearings that the Governmental Affairs Committee is holding on the causes and consequences of alcohol abuse and alcoholism.

Today's hearing will be concerned with some of the legal approaches to alcohol abuse prevention in this and other countries and how effective they have been.

We were going to have another hearing tomorrow. For other reasons of Committee scheduling we have had to cancel that particular hearing, so I wanted to announce that this morning. It will be rescheduled to a later date. We haven't cancelled it, we just postponed it, so I wanted to let you know about that.

The goal of our Nation's prevention strategy should be to reduce the incidence and severity of alcohol-related problems. Now, obviously, how well these programs work will largely determine whether and to what extent our country can reduce the devastating impact of alcohol addiction. We don't look at this too often as a drug problem, yet alcohol is a drug. The only difference between that and other drugs in our society is this one is legal. This is a licit drug, not an illicit drug.

The seriousness of the alcohol abuse threat to the public health of our Nation and to the future of American youth has been largely overstated by our national preoccupation with the use of the illicit drugs such as marijuana, crack, heroin, and cocaine.

I don't have any desire at all this morning to minimize the impact that the use and the sale of illicit drugs have on our country. We should keep in mind that the use of a legal drug, alcohol, is exacting a very heavy toll on our Nation. Alcohol has been reported to be a factor in nearly 50 percent of all suicides, homicides and accidental deaths in this country. Consumption of beverage alcohol has been associated with an increased risk of developing liver disease, hypertension, cardiovascular disease and even certain forms of cancer.

About two out of every five people in the United States—that's 40 percent of our people in the United States—will be in an alcohol-related automobile crash at some time in their lifetimes; 40 percent of our people. Of the 46,056 highway deaths in 1986, 52.1 percent were alcohol-related. On any given evening when you are driving home from work, or your wife is driving home from shopping, or a family member is driving in the early evening, about 3 percent of the cars coming towards you will be driven by people who are to some degree under the influence of alcohol.

What happens on weekends? Experts estimate that on Saturday evening during that same period, as many as 20 percent—one out of every five cars coming toward you—has a driver that has been drinking; 20 percent! Think about that. That is a startling figure to me. In all, an estimated 100,000 to 200,000 lives are claimed by alcohol each year while only a little over 4,000 to 6,000 deaths are attributed to the use of illicit drugs.

One out of every three American adults, or almost 56 million Americans, report that alcohol abuse has brought trouble to his or her family. This is about four times the number of families that say that other drugs have caused problems in their homes.

I am not trying to say that we call off any of the attention to the hard drugs at all. I am just saying let's put the dangers of drug abuse in perspective compared with the problem of alcohol abuse and put some emphasis back here on some of these things also.

With our collective preoccupation with the war on drugs, it is easy to forget that last year alcohol stood out as the most widely used and abused drug among adolescents and teenagers in this country. A recent survey reported that nearly all high school students—in fact 92 percent—have tried alcohol, with two-thirds reporting having used alcohol within the past month; 5 percent of graduating seniors report being daily drinkers while almost 40 percent have had at least one occasion of heavy drinking within the last 2 weeks.

Kids today also begin drinking at younger ages than their predecessors. The average age at which youngsters begin drinking, have their first experiments with drinking—what would you figure? 18? 20? 21? 17? 16? It is 12; 12 years of age!

Over one-third of fourth graders—that is our 9 and 10 year olds—one-third of them who were questioned about peer-pressure to drink alcohol in a recent Weekly Reader's survey answered that they felt pressured to drink—can you imagine? Alcohol surveys going out now in the Weekly Reader—that in itself is startling enough. But to these 9 and 10 year olds questioned in a recent Weekly Reader's survey had experienced peer pressure to drink alcohol. It is popular in school, 9 and 10 year olds.

It should be a national disgrace that an estimated 4.6 million kids between the ages of 14 to 17 report having problems associated with the consumption of beverage alcohol, and young men between the ages of 18 and 24 have the highest reported rate of problem drinking.

Given these sobering statistics, is it any wonder that alcohol-related highway deaths are the number 1 killer of young adults between the ages of 16 and 24?

Prevention is the key to victory in the war against alcoholism and other drugs of abuse. Therefore, the strategies being used to change our attitudes and behaviors about alcohol must be effective if we are to reduce the social and economic costs of alcohol addiction in this country.

Substantially more attention and research dollars need to be devoted to the prevention of alcohol abuse and addiction. While the Federal Government only targets $18 million per year to its alcohol abuse prevention activities—$18 million a year—the alcohol beverage industry spends over $1.3 billion annually—$1.3 billion compared to $18 million—they spend that $1.3 billion to promote beer and wine, wine cooler and liquor consumption.

Clearly something is amiss in our social priorities when in a single year the advertising budget for a single brand of beer—just one brand of beer—is twice the annual budget of the National Institute on Alcohol Abuse and Alcoholism.

We welcome very much this morning the participation of Senator Strom Thurmond of South Carolina to this vitally important hearing. Strom has been an advocate for, and sponsor of, alcohol warning label legislation in this and in previous Congresses. I have co-sponsored this legislation since I believe that health messages on alcoholic beverages can be an effective component—just one component, we don't expect it to solve the whole problem, but it is a start—it can be an effective component in this Nation's prevention strategy.

We are also honored to have with us today Dr. Marcus Grant of the World Health Organization as well as other investigators and advocates in the fields of alcohol abuse prevention and intervention.

So I thank you all for coming to this hearing and look forward to an absorbing day of testimony.

I must apologize for starting our hearing a half-hour later than we orginally wanted to start it this morning, too, but I had to go over and give some testimony before a Committee in the House.

So we welcome you, Senator Thurmond. We know of your long interest in this and look forward to your testimony.

Thank you.

TESTIMONY OF HON. STROM THURMOND, U.S. SENATOR FROM THE STATE OF SOUTH CAROLINA

Senator THURMOND. Thank you very much, Mr. Chairman.

Mr. Chairman, you are to be commended for holding this hearing on efforts to prevent alcohol abuse and I appreciate the opportunity to appear before this Committee.

In my opinion, a key component in any effort to prevent alcohol abuse is making the consumer more aware of the risks involved in alcohol consumption. In this regard, I would like to call the attention of this Committee to my bill, S. 2047, and to update the Committee on its progress. Incidentally, I greatly appreciate the Chairman's co-sponsorship of this measure. Senator Glenn's support in this matter has been invaluable.

Mr. Chairman, I first introduced legislation regarding the adverse health and safety effects of alcohol consumption in 1969. I have regularly introduced similar measures since that time. In 1979 the Senate passed the alcohol warning label legislation. I will continue to fight for what I consider to be vital legislation to protect the health and safety of the American public.

S. 2047, as originally introduced, would have required five rotating labels on beer, wine and distilled spirits. However, after extensive discussions with Senators Ford and Danforth, we agreed on a one-label format. Based on the modifications which resulted from these discussions, the Senate Commerce Committee unanimously reported S. 2047 last Tuesday and Senator Ford has now cosponsored this measure.

As reported, S. 2047 would require the following warning on all alcoholic beverages:

> Government warning: (1) According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects.
>
> (2) Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery, and may cause health problems.

Mr. Chairman, some have argued that the labels have no effect because the public is already aware of these problems. If that were true, would fetal alcohol syndrome still be the third leading preventable cause of birth defects, and would we still be losing almost 25,000 lives a year on the highways because of alcohol?

Mr. Chairman, common sense tells us that consumers need to be more aware of the effects of alcohol, and experts in the field have long been calling for alcohol warning labels. As far back as 1977, Food and Drug Commissioner Donald Kennedy, urged the Bureau of Alcohol, Tobacco and Firearms to require warning labels on alcoholic beverages about the risk of alcohol during pregnancy.

Mr. Chairman, just last year the Department of Health and Human Services released a report concluding that health warning labels do have the potential to effect consumer behavior, particularly, in combination with other educational efforts.

Secretary Bowen's letter, accompanying this report, outlines the many health hazards associated with alcohol use and states that the magnitude and severity of these health effects argue for sustainable and highly visible public health efforts.

Mr. Chairman, I would like to quote one paragraph from Secretary Bowen's letter directed to me, dated August 3rd, 1987:

> Consumption of alcoholic beverages is associated with a wide range of serious health hazards, including birth defects, impaired motor skills, adverse drug reactions, excess morbidity and premature mortality due to liver damage, hypertension, and cancer among other illnesses. Nearly 100,000 deaths are attributed annually to alcohol consumption. In addition, the economic and social costs associated with alcohol use are staggering. In 1983 they reached $117 billion. By 1990 they are estimated to reach $136 billion and in 1995, to increase by an additional $15 billion, up to $150 billion. In brief, the magnitude and severity of these health effects argue for sustained and highly visible public health efforts.

Mr. Chairman, I was pleased to learn that Secretary Bowen has personally endorsed the use of warning labels on alcoholic beverages. This legislation will assist in prevention efforts by accomplishing the following:

Warning labels get people to think about the substance they are using. A heightened awareness of the health effects of alcohol may lessen problems related to alcohol. Warning labels on alcoholic beverages will provide information to people who may not have access to formal medical care, especially in the prenatal care situation.

Labels raise the visibility of the issue for health professionals so they may be more inclined to routinely discuss alcohol-related issues with their patients. It will increase knowledge among young people that alcohol is a drug and that drinking and driving do not mix. Also, it will help to counter the glamorous view of alcoholic beverages promulgated through over $2 billion in alcohol advertising. Between the ages of 2 and 18, American children see 100,000 TV commercials promoting beer. That is amazing!

Mr. Chairman, warning labels are not a cure-all for the many problems caused by alcohol. However, they can be an important and cost-effective component of a broad public health approach to the prevention of alcohol-related problems.

Mr. Chairman, I ask unanimous consent that a copy of Secretary Bowen's full letter be accepted for the record.[1]

Chairman GLENN. It will be included in the record.

Senator THURMOND. Mr. Chairman, I also ask unanimous consent that a list of organizations supporting warning labels—which I believe is over 100 organizations, such as, the American Academy of Pediatrics, the American Medical Association, the American Cancer Society, the American Heart Association, the American Liver Foundation and others be listed.[2]

Chairman GLENN. It will be included in the record.

Senator THURMOND. Mr. Chairman, I want to thank you again for your deep interest in this important issue. I don't know of any one subject in which the Chairman could take a greater interest that would help the people of America more than that of the alcohol situation. As the Chairman stated in his opening statement, illegal drugs, of course, are terrible and we should do everything we can to eliminate them. However, the one drug that causes more deaths, causes more automobile accidents, and causes more disturbance in the population of America is alcohol.

Thank you very much, Mr. Chairman.

Chairman GLENN. Thank you very much Senator Thurmond. I appreciate your testimony this morning.

Secretary Bowen's report lists quite a number of things that he thinks should be done, one is the health warning label. There are quite a number. I will not read all of these things off. They are in the report, but on the labeling, he has a paragraph in there in the section that describes his views on that.

It says this: "Beverage alcohol, the most widely destructive drug in our society, remains exempted from a number of standard consumer information requirements including content and health warning labels. Numerous consumer products bear health warning labels, including cigarettes, smokeless tobacco, over-the-counter medications, aspirin, prescription drugs and products containing saccharin. None of these products is responsible for the massive societal health and economic damage as that caused by the use of alcohol."

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[1] See p. 370.
[2] See p. 504.

Then he closes with this: "It is a curious result indeed that wine coolers with saccharin display a warning label about the dangers of saccharin but not about the dangers of alcohol."

I thought that was a notable thing that jumped out at me when I was reading some of this in preparation for the hearings last night.

So Senator, we appreciate your comments very much and your testimony will be included in the record as well as the other things that you indicated.

Thank you very much for your leadership in this area.

Senator **Thurmond**. Thank you very much.

Senator **Glenn**. Our next witness is Dr. Marcus Grant of the World Health Organization, Geneva, Switzerland.

Dr. Grant, we indeed welcome you to the hearings this morning and look forward to your testimony. You have had a little more of a world view of some of these things perhaps than most of our people have had, so we look forward to your testimony this morning and thank you for being with us.

TESTIMONY OF MARCUS GRANT, PH.D., WORLD HEALTH ORGANIZATION, GENEVA, SWITZERLAND [1]

Dr. **Grant**. Well, thank you very much indeed, sir, for the opportunity to be here. It is relatively rare, I think, for a staff member of the World Health Organization (WHO) to appear before committees such as this and therefore it is a very special privilege to be here.

Chairman **Glenn**. Maybe when they have your expertise we should be solicitous of more testimony from that source.

Dr. **Grant**. You can make your own judgment after you have heard me.

I think what I will do that may be of use to you and your Committee is perhaps to try to summarize evidence from around the world that is relevant to the issues that you are confronting here. In doing that, I am going to draw on a number of key WHO documents and reports and I would just like to pay tribute to the fact that one of the most important of those was prepared for us by the Director of the Policy Analysis Division of the National Institute of Alcohol Abuse and Alcoholism of the United States, which is also a WHO collaborating center.

I think that one of the most striking features of recent years, perhaps of the last decade internationally, has been the mounting concern that has been expressed about alcohol-related problems. Delegates of the World Health Assembly which takes place each May in Geneva have been expressing with increasing severity and with increasing enthusiasm their willingness to take action. I think the main reason for that has been a recognition that rates of alcohol consumption—and therefore, as you well know by now, associated rates of alcohol-related problems—have been mounting around the world.

The most worrying feature of this trend is that whilst consumption rates and problem rates in countries like the United States and industrialized countries of Western Europe have been either falling or leveling off, the rates of increase in the developing world have been very sharp indeed. There are countries in the African region, for example, in which recorded consumption of alcoholic beverages is virtually doubling every year.

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[1] See p. 229 for Dr. Grant's prepared statement.

Now, it is true, of course, that these countries begin from a very much lower base in terms of per capita consumption than would be, let's say, in the United States, but nonetheless, a rate of increase as steep as that, carries in its wake the likelihood of very severe alcohol-related problems, both now, and more particularly, in the years ahead.

I was very struck, sir, in your opening remarks when you talked about the necessity to have harm reduction as the mainspring of a national policy. We brought together in Sidney and in Canberra, Australia, earlier this year a group of experts from all WHO regions to try to identify what were the key elements in healthy public policy on alcohol and drug abuse, and I will just read two sentences from the consensus statement which that group put together.

It is an item called "Principles of Healthy Policies on Alcohol, Tobacco and Other Drugs," and the first two sentences say this: "The overall aim of public policy should be to improve the health and increase the well-being of all people. National policies on alcohol, tobacco and other drugs should seek to contribute to this aim by reducing as far as possible the harm associated with the use of psychoactive substances."

So your remarks certainly reflect the growing international consensus.

Given the seriousness and the severity of the problems, I think the most important point to stress at the outset is one that should encourage us and give us grounds for optimism, namely that there is now good evidence that alcohol-related problems can be prevented and that they can be prevented by actions which governments can take.

What I would like to do is just to summarize very briefly the main elements of a healthy public policy for which there is some evidence, drawing upon the international literature in doing so. The full evidence for this is contained in the written testimony which has already been submitted to you, but all I would do just now would be to identify the main elements.

I do that under three headings. First of all, measures for which there is now really quite good international evidence of effectiveness. Second, measures which are widely believed to be effective, even though the evidence may be lacking; and thirdly, measures for which the evidence is somewhat mixed.

In the first category, that is to say, measures where there is good evidence of effectiveness, there is now, I think, no doubt at all that increasing the price of alcoholic beverages relative to other products does have an impact upon consumption and that impact upon consumption is reflected in the rate of alcohol problems. There is evidence from both developed and developing countries to support that assertion and that is contained in the written testimony.

Second, in this category, that sharp restrictions on the availability of alcoholic beverages do have an impact upon consumption and again that that impact is reflected in rates of alcohol-related problems. I think it is important to emphasize here the adjective which I use, "sharp restrictions." When it comes to giving evidence on the issues where we have mixed experiences, it is clear that tinkering with availability, making minor changes to licensing laws, for example, may have a rather less impressive impact, but sharp restrictions on availability certainly do have an impact.

Third, increasing the minimum drinking age. In many countries, including your own, sir, it is true that there is an age below which it is not legal for young people to consume or to purchase alcoholic beverages. The precise legal requirements vary from country to country and in some countries whilst there may be a law on the statute books, its enforcement is not always as rigorous as it might be. But where the minimum drinking age has been raised, as it has been in a number of states in the United States, it is clear that there is an impact, particularly in one of the indices that you mentioned in your opening statement, that is to say, alcohol-related casualties, particularly on the roads.

I just emphasize, since I am reflecting experience in developing countries as well, that one might think that in countries where motor vehicles were less common that this would be a less important measure. In fact, that is not so because there are many other kinds of casualties associated with the frequent intoxication that occurs when young people have easy access to alcoholic beverages.

The fourth measure in this category, that is to say those for which there is good evidence of effectiveness, is where one can increase the probability of being detected and punished for drunken driving. I am sure that this is an issue which you have heard evidence from in terms of experience within the United States, but it should be, I think, important to note that the international evidence reinforces what you have learned here; that is to say, when people believe that there is a good chance that they will in fact be detected for driving above the legal limit and where they believe that that detection will be followed by a due process of law resulting in their conviction and punishment, then it does have an impact upon their behavior. It does cut down the number of drunk drivers on the roads and that has an immediate impact upon fatalities and other casualties.

So these, I think, are the four measures for which there is good international evidence of effectiveness. There are two measures where there is broad international consensus that they are important and worth pursuing but where the scientific evidence currently available is perhaps not sufficiently strong to warrant the enthusiasm that is given to these. These are both educational strategies.

The first is providing broadly based health education or health promotion programs, either for school children or for the general public. Many would argue that it is important in order to provide a context for other changes such as legislative changes. Such an educational thrust should co-exist with these changes. It has to be recognized that what it may do is to reflect a changing climate of opinion within society in general but at the same time if we are looking for a direct impact upon the behavior of individuals or groups, it is difficult to mirror the enthusiasm of the advocates of education with the scientific evidence. That may, however, not be any good reason for not pursuing educational strategies since they appear to have this broad consensus, even from those who might in other circumstances oppose other measures.

Similarly, the education and training of health professionals and indeed professionals from other relevant sectors such as law enforcement, is something which many people feel to be very important but where, again, the evidence at present is insufficient to justify perhaps the extent of the enthusiasm.

Nevertheless, it is clear that there will be alcohol-related casualties and problems for the forseeable future and that health and other professionals are going to have to deal with those and therefore to educate and train them in what is important.

Equally, however, these same health professionals and others are going to have to become increasingly involved with preventive issues as well, and perhaps it might be worth pondering what initiatives one could take in increasing the capacity of health workers, particularly at the primary health care level, to become involved in preventive programs within the community.

Then there are measures for which the evidence is somewhat mixed. That is to say that it is not that there is no evidence or that the evidence is negative, but that negative and positive evidence appear to lie side by side and that it depends really upon the position you begin from which you give the greater weight to.

The first I have already mentioned. That is to say, making smaller changes in the availability of alcoholic beverages; tinkering, I think, was the word I used—tinkering with the availability.

Sometimes it seems to make a difference, sometimes it doesn't and it is very hard to know whether that is something that depends upon the circumstances and the opportunities or something where with more time we might see a longer term impact, particularly if the tinkering were all going in the same direction.

Sadly, the experience of countries is that tinkering tends to be just that. It goes one way one year, another way the next, and it is difficult to point to long-term effects.

The second measure for which the evidence is mixed relates to the regulation of advertising and promotion. It is clear that some studies have indicated a direct link, a causal link, between changes in the regulations governing advertising and promotion and the consumption of alcoholic beverages and the associated problems. Other studies have demonstrated no such link. It may be, however, that society chooses to make whatever regulations it wishes to in this area less for reasons to do with the direct impact upon problem rates than as a method of signaling a concern with a particular area.

I think that in this country you have a tradition of negotiating agreements with the beverage industry and this is something that has occurred certainly in a number of other countries where there is a long tradition in the production of alcoholic beverages.

Again, I think the evidence is mixed. In some countries it has been argued that agreements which are reached in full consultation with the industry are more likely to be honored by all parties and that those that are imposed by government may in fact be not only less popular with the industry but less effective. The evidence on both sides has mounted but is difficult to bring together in terms of a coherent conclusion. I think probably what is culturally consonant is what one goes with.

The third measure of this sort has to do with encouraging the consumption of lower alcohol content drinks or drinks with no alcohol in them at all. Clearly people like to drink. They like to take liquid and put it down their throats. They need to do so to survive and one way of reducing alcohol-related problems might be to encourage the consumption of drinks that contain less ethanol. Again, the evidence here is somewhat mixed.

Finally, in this area, there are other strategies, such as reducing workplace accidents, preventing problems in the adult children of alcoholics, making the world safer for people who are intoxicated so that even if they get intoxicated, they are less likely to injure themselves. All these are possible areas in which one should be investigating whether or not the impact is as positive as it might be.

I think that in broad summary what I have tried to indicate is that there is sufficient evidence to indicate that alcohol-related problems can be controlled through legislative action. Not only is there evidence to support that, but there is a mounting need to do so, an urgent need to do so. That need is felt world-wide and it is felt individually in member states such as the United States of America.

International bodies like the World Health Organization have a limited role to play. Our job is not to tell member states what they should do. Our job perhaps is first of all through advocacy to encourage the development of healthier public policies and secondly, through disseminating information about appropriate technology to promote the most effective programs that are possible within any given cultural/social context.

Mr. Chairman, every country in the world has an alcohol policy. Every country has a de facto alcohol policy. It may not be written down in one place, but it exists. It exists in the different interests of different government departments and of bodies outside government.

I would suggest, sir, that the diversity of interests is not an impediment to action but really something which creates the chinks of opportunity within which action can take place. And I believe you have the opportunity here to seize those chinks and to act now.

I would only end with one word of caution. Alcohol-related problems do not stop at national boundaries any more than do the problems that you have mentioned in your opening statement in relation to illicit drugs. If we have learned anything from the illicit drug area, we should learn that the old traditional differences between poor countries and consumer countries are not as relevant now as they used to be. I would suggest that that was equally true for alcohol-related problems. So alcohol policies should not stop at national boundaries either.

From the international perspective, sir, it would be a missed opportunity if newly muscular United States policies encouraged the producers of alcoholic beverages to export even more of your problems from this country to the developing world than are being exported just now. I would ask you to bear in mind in considering preventive policies not only the prevention of problems in respect to your own citizens but the citizens of the world.

Thank you, sir.

Chairman GLENN. Thank you Dr. Grant, very much, for bringing us that international perspective. Let me bring it back to a local political note here, and not a political note, but a note of your budget up at the United Nations.

The World Health Organization has done good work on this in the past and you have been affected, as other U.N. agencies have, by the United States being in arrears in paying our U.N. assessments—I believe that your portion of 1985 to 1987 was $17.6 million that we were in arrears, and $10.1 million for 1988, fiscal 1989.

Does this recent paying up of our assessments at the United Nations mean that you now get those funds? Or do your funds come out of a different budget than that one? Can you tell me that?

Dr. GRANT. Well, within each program the funds made available come both from the regular budget and from extra budgetary sources. The regular budget is the one that you are referring to when you talk about the payment of arrears.

Clearly, when the United States Government was significantly in arrears, an emergency plan had to be introduced which had an immediate impact upon all programs, including the program for which I am responsible, which is the global program for the prevention and control of alcohol and drug abuse.

Measures had to be taken which meant that activities which had been planned did not occur, and these, I am afraid some of them could not even be started. Now that the position is somewhat more optimistic, I certainly have been able to crank my program back up again so that activities that I had hoped to undertake can now be undertaken.

On the other hand, I think one must recognize that the position, although improved, is still far from ideal and that there are many opportunities for enhancing that now.

Chairman GLENN. Well, will you now, though, get that money which for the 2 years combined would be $27.7 million? Will you now get that funding?

Dr. GRANT. Well, the organization will get that. My portion of it, though, will be very, very small.

Chairman GLENN. Okay. All right. Well, fight it out with them up there.

You relate in your testimony that while alcohol consumption and alcohol-related problems appear to be leveling off in some of the developed countries in Europe, it is not the case, of course, in a number of developing countries in Africa, the Americas and the Western Pacific.

Why these huge increases and why the leveling off? Have we just become so satiated with alcohol that the increase is not going up and they are just starting out on a track we have already followed? Is that it?

Dr. GRANT. It is a difficult question because there are many reasons. I think that there is in many industrialized countries greater consciousness now of the fact that excessive drinking does cause health problems and that has contributed to that leveling off. People are more health conscious generally and that relates also to their drinking. But in developing countries, the situation is further complicated by the fact that a great deal of alcohol which is consumed is what is called nonrecorded consumption; that is to say, it is alcohol which is produced domestically, sometimes legally, sometimes illegally, but that is not quantified. All we can quantify with any degree of accuracy—and even that is less than we would like in terms of accuracy—is commercially produced alcoholic beverages.

Now, one could argue that one reason for the very steep increase in the developing world is that there is now greater availability of commercially produced alcohol, in part because of the increased involvement of multiple national corporations in the indigenous beverage industry of many developing countries.

Now, some would say that that is a good thing because at least the quality of those beverages is assured whereas the quality of domestically produced beverages isn't. These people might also argue that perhaps the commercially produced beverages are being substituted for the locally produced beverages. Our evidence is very slight, but such evidence as we have would indicate that that is not the case, that in fact it has been added on top of the domestically produced beverages. So the real rate of increase is in fact even greater.

Chairman GLENN. Let me ask you on a specific country. We see all the ads on TV. We see the wine connoisseurs magazines and all that all originate in France, or most of them seem to, and the French have the reputation of—in all due respect to anybody of French heritage here this morning—I'm not taking a crack at the French except I think it is generally accepted around the world the French have been great wine drinkers, high consumption of alcohol, one of the highest in the world, and you mentioned in your testimony that per capita, consumption of alcohol declined in France by some 27 percent between 1956 and 1982.

Now, that is a rather lengthy period. But they also had corresponding decreases in alcohol-related health problems. Now, what was the program there? How did they bring that about? Did it occur naturally? What brought that about and why cannot we follow some of the same things they did, if it was a planned program of reduction? Or was it?

Dr. GRANT. I certainly think that there will be opportunities for following what they did. It was a planned program of reduction, and what was impressive was that it involved a number of different sectors of government. It involved the Health Ministry, but it also involved the Justice Ministry and the Treasury and the Road Transport Ministry. They worked together. They actually did not pursue separate interests but pursued a common interest, recognizing that in the end the economic impact upon France—these very, very high rates of alcohol problems—were simply unacceptable.

So there was a public education campaign, there were changes in legislation, taking up some of the points which I mentioned in my testimony, and all of those were part of a relatively well integrated policy, so that each component reinforced the other.

Chairman GLENN. Well, I have been at dinner in French homes in France, and you probably have too, where the children had dinner along with you and everybody had the wine. The children had wine, maybe mother poured a little water in it to water it down a little or something like that, but the children, even small children, very small children drank wine. It has just been a way of life there and I was—I did not realize that they had had some 27 percent reduction. I thought that was rather remarkable. Your figures are between 1956 and 1982.

What about the 6 years since 1982? Has consumption gone back up or leveled off or declined further?

Dr. GRANT. The same trend has continued but somewhat less sharply in the remaining 6 years. I think it may be that the rate of decrease has diminished but the trend is still the same. And I think it is worth pointing out—bearing in mind what you said at the beginning about harm reduction—that there has not been an attempt in France to, for example, create an abstinent society.

Indeed, the motto of the television campaign has been [French phrase] which means, "One glass, that is fine, three glasses and your troubles really begin."

So it has been reinforcing a message which has been saying, wine in itself is something which is still part of the culture but only to a very limited extent. One glass.

Now, I am sure that when you visited French homes people drank more than one glass. Nowadays I think if you were to visit those homes, you would see that people, whilst they still had their bottle of wine on the table, would be drinking considerably less than they have been doing previously, so that it is something which has been broadly spread throughout the whole drinking population.

Chairman GLENN. Has this been done basically with an education campaign of moderation, then?

Dr. GRANT. The education campaign has reinforced the movement within the legislation.

Chairman GLENN. Wine is a little bit different than beer and so on, which is so widely used in other countries. Is there any indication or do you think in your experience with these problems, that an education program like that would work just as well with beer as it would with wine?

Dr. GRANT. I think there is no reason to suppose, sir, that the nature of the beverage is important. It would change the nature of the campaign. I am sure that the same campaign would not work for scotch whiskey or for Japanese saki or for Budweiser beer. But the possibility of having an educational campaign consonant with changes within the legislation is something that should be given very serious thought.

Chairman GLENN. Did the French do this mainly as a TV, magazine, newspaper campaign? Did they require certain amounts of public service advertising, as we would call it in this country here, to match the——

Dr. GRANT. The educational campaign appeared on television with great regularity, and what was very interesting was that this phrase [French phrase], which is hard to translate, but it means roughly "your troubles begin," was not a phrase that had previously been a popular phrase in France. It wasn't taken up. It was created by the advertisers and now it is a phrase that you will hear everywhere in the streets of France, not just in relation to alcohol but it has entered into the popular talk of French people. And that means that in a sense each time it is used, it reinforces the message for which it was originally created.

Chairman **Glenn**. How about schools. Was there a big school campaign along with this?

Dr. **Grant**. There was a school campaign but I think that the main target was in fact those people who are most at risk; that is to say, middle-aged male drinkers.

Chairman **Glenn**. You mentioned four measures that have reasonably good evidence of effectiveness in reducing consumption and problems associated with consumption. You listed them, I presume, in what you thought was the order of their effectiveness. You had price, restricting availability, minimum drinking age and the detection of punishment for drunkenness, drinking and driving. Were those in the order of effectiveness?

Dr. **Grant**. Well, that is a very good question, a difficult one to answer, but the question is, what counts as effectiveness. Does that mean the largest possible reduction in alcohol-related damage or the measure that can most easily be implemented?

My suggestion would be that it would be very unfortunate if one were to go on only these counts, if any one by itself is going to do very much less than all four taken together. The increase in the effectiveness would be incremental as one moved through these measures. To take any one, it can look like an isolated piece of policy unrelated to a broad social concern. Take all four and you are running with a winner.

Chairman **Glenn**. Have any of the nations used the pricing area? Now, we look at taxes as a way of raising revenue and they are commonly called the "sin taxes." You take the beer, cigarettes and alcohol taxes and so on, have any countries tried to use taxes to deliberately keep the price up as a way of controlling alcoholism?

In other words, have they said, okay, if we put the price up here at a certain level, we know that is going to restrict it because it is one of the effective ways of doing this, and so whatever they charge for the beer, say, or whatever it is, we are going to tax up here enough that it hurts as a means of controlling the flow of alcohol and alcoholism? And it is not mainly a measure of raising taxes, it is primarily a means to control consumption.

Has any nation tried that?

Dr. **Grant**. Well, all the Nordic countries do that. The situation is somewhat different there in that they have a state alcohol monoply in those countries. But the legislation, for example, that surrounds the Finnish State Alcohol Monopoly, specifically states that the price of alcohol must be set at the level which is consonant with the greatest public good. That is within the legislation that has set up the state alcohol company, so these countries have a tradition.

In the United Kingdom where I was on Thursday and Friday of last week, there is a concern now there about the harmonization of tax levels across the European community and I was interested to see that the Chancellor of the United Kingdom was using an argument to do with health costs in relation to his resistance to some of the proposals from the European community, saying that the current relatively high level of taxation on alcoholic beverages in the UK was a deliberate health policy. To be fair, that has not been said necessarily at the time of the budget but it was being said now at the time when the current level was threatened with being reduced.

Chairman GLENN. Number two, restricting availability. Do most countries in your experience restrict the availability only of the hard liquors and the wines or the higher alcoholic content wines as opposed to beer and the lower alcoholic content drinks? In other words, let me just explain what I mean here.

We have package stores in this country, quite common. The State controls them. Some States have liquor control by liquor only being sold through State-controlled stores. But beer and the lower alcohol content wines available at supermarkets and wherever you want to, whatever drive-in you want to drive through and pick up the trunk load of beer or whatever.

Now, when you say restrict availability, is that type thing effective in some countries? Or when you say restrict availability, as your number two item on controlling this, are there countries where they control all alcoholic beverages through package stores? They are less available, they are not at the corner tavern or the supermarket.

Are there countries that do that, control everything that has alcohol in it through package stores?

Dr. GRANT. Yes, there are. You will be aware, sir, that in the way you phrase the question that there is an implicit educational message. If there were one system of control for hard liquor and one system of control for wine and another system for beer, the implicit message is hard liquor is dangerous, wine is civilized, and beer is a grocery product.

Now, we know that all three contain ethanol and that ethanol is a substance that concerns us because of its toxic properties, its carcinogenic properties and because it is an addictive drug. And therefore, whilst it may be that one is looking to different levels of taxation for different alcoholic beverages in the light of the concentration of ethanol within them, the issue of their availability must take into account the fact that it is ethanol which is the active health damaging ingredient in all the beverages.

Chairman GLENN. Your third item was a minimum drinking age. How do other countries enforce that? That is a little difficult here where beer and wine are at home. I would think you would have the same problem in other nations, too, that beer and wine being available at home, means the kids are going to get into it when dad and mom are out someplace, and that is as true in any other nation as it would be here.

So how do you restrict it, or how does the minimum age drinking age work? Granted you can make a minimum drinking age to go in and order a drink over the bar, or you don't sell to kids; you don't sell beer to kids in the supermarket. But it is still available, quite widely available.

How does the minimum drinking age work?

Dr. GRANT. Well, of course, that is absolutely true and it is fair to say, second, that much of the evidence for the effectiveness of this measure comes from North America. But it is worth noting that its effectiveness is in terms of the acute effects of alcohol if it is people who damage themselves because they get drunk.

Now, I would put it to you that if a young person gets drunk in their parent's house, they are less likely to damage themselves than if they get drunk somewhere that is distant from their home and they then have to travel back to their home. So it may be that here what one is talking about has much to do with the circumstances within which such legislation is enforceable.

You cannot enforce it within the privacy of somebody's home; at least you could, but only by invasion of privacy that would be unacceptable within a democratic country.

But you can enforce it in places where alcohol is being sold. These may be places where it is much more important to enforce it because the risks are greater associated with consumption, either on these premises or nearby.

Chairman GLENN. Detection and punishment for drinking and driving was your fourth item there. That is one we have all been— or we are all familiar with, at least, with being in Sweden or some of the Nordic countries where you have a designated driver and you either all come in a taxi cab or you have a designated driver who is going to drive everybody home and when they bring the drinks around for everyone, where there is wine and cocktails and so on on a tray, there are always two or three little glasses of orange juice or grapefruit juice for the designated driver. That is just accepted and it seems to work fairly well.

Because they know that—I don't know what the penalties are right now, but in Sweden back when I was there some years ago I think the penalty was on the first offense of drunk driving it was like you lost your license for a year, or 2 years, and if you got caught driving during that time period you lost it for life and a prison sentence went along with it, I think.

And they are very, very tough on this. Far tougher than we are here. That seemed to work over there. I don't know what your statistics are on Sweden and some places like that with this kind of a policy, or other nations, but it means that you have to have a very effective law enforcement program and judges that would back it up that are tough, far tougher than the average judge in this country.

Most States here have laws against—all of them, I presume— have laws against drunk driving but you get a $50 fine or a $25 fine and we feel you are really being tough if you make them go to a 3-day 4-hour, 5-hour driving course or some little school of some kind because you are caught drunk driving. The second offense maybe is a little more, and the third, then you begin to get a little tougher. It is pretty weak compared to what some of the programs like Sweden have.

Do these really work and does it require that kind of strict enforcement to have any impact at all?

Dr. GRANT. The answer, first of all, is, yes, they do seem to work. It is true that in the very long term the effects sometimes diminish unless the legislation is kept under review, but all the same, in countries that have taken those measures, there usually is sufficient political will to insure that indeed the measures are kept under review. It is worth mentioning that we are not just talking about the Nordic countries, which are sometimes seen as being almost killjoy in the extent to which they wish to limit the inappropriate consumption of alcoholic beverages.

We are talking about Australia, a country which certainly has a reputation for boisterous and happy drunkenness. We are talking about Japan. We are talking about a number of countries from around the world where once legislation has been introduced and has been perceived to be effective, then its impact is increased substantially. It is worth mentioning that it is not just the severity of the punishment that is crucial but the extent to which the driver perceives the likelihood of being arrested, convicted and punished a realistic one, so that they are deterred from taking that first drink, or in some circumstances, that second or third drink, before getting into the car. And that means that they really have to be convinced that they are running too high a risk in doing that.

Chairman GLENN. You had, as some of the secondary or the other things that are being considered but perhaps would not be as effective as those four primary areas you mentioned, of price, restrict availability, minimum drinking age, detection and punishment for drunk driving. Those were your big four.

Then you went on to some others. On education, you had that listed as some other things for which there is little less evidence of the effectiveness.

Now, I would think when you put under that one, number 1, then, schools and general public awareness programs and so on under education, that that sort of grading it that far down sort of flies in the face of the French experience, which you said was mainly education and public awareness and so on.

Why was that not up as number five in your prime list?

I am not telling you how to organize your material, but I am wondering why it was downgraded, because I think that is what we assume is going to do a great job if we get on it.

Dr. GRANT. I could tell you, sir, there are two reasons for that. One is strategic. One is tactical. The reason for not putting it in the top four, making them the top five, is that France is currently one of the very few examples that one can find where there has been that degree of consistency in an educational program over a sufficiently long period of time to be able to point to a comparable change in behavior, and at the same time, as I mentioned when we were discussing the issue of France, it ran in parallel with legislative changes. It did not exist in isolation, whereas some of the evidence for the other measures are of their effectiveness in isolation. Education's greater impact may be in reinforcing changes which are occurring within society.

The second reason and the more tactical one, is that I think education can be perceived as a soft option. I am certainly aware of some countries which have decided that having introduced an educational program in schools, they have therefore solved the alcohol problem and need have no concern for any of the four measures that I have listed above it in this paper, so that there is a worry there that people might think that by giving a little bit of alcohol education in schools, they have done the trick. They would not have done the trick.

Chairman GLENN. Well, we are depending very heavily on educational programs, though, to really sort of turn the tide here in the hard drug program eventually. We know it is going to be a long haul. It is going to be 10, 15 years of keeping the pressure on to make peer pressure—what your colleagues, your peer pressure say—the peer pressure is, if you are using hard drugs, do not; that is bad stuff, do not do that, do not come around my house. I do not want to associate with you in school or any place else if you are using hard drugs.

That is sort of the ultimate of the education program, and we are depending on that with the hard drugs, to solve this thing long term.

What you are saying though, that with the legal drug of alcohol, that you do not feel that is going to do that. Is that right? What is the difference between alcohol and the hard drugs as far as an education program goes? We are putting a lot of stock in the education program here and yet you have downgraded it a little bit from where I thought you probably were going to have it in your list of things to do.

Dr. **Grant**. I think there are two good reasons for the change. The first is that you already have an enormous investment in the law enforcement side with respect to illicit drugs, the control side, the limitation of availability side. Many, many, many millions of dollars are already being spent in that area through customs activities, through law enforcement, through police activity, so that if one were to compare, if you like, the supply reduction side on illicit drugs to the supply reduction side on alcohol, then in illicit drugs for many years the emphasis has been on supply reduction.

And what you are doing in your educational program with respect to illicit drugs is giving perhaps a little bit more due regard to demand reduction strategies because after all one cannot be terribly impressed by the effectiveness of the law enforcement activities in this area, since the utilization of illicit drugs is continuing to increase.

That is the first reason. The second is that illicit drugs are just that. They are illicit and therefore you have a handle there for your educational programs which is not present in alcohol. It is true that the purchase of alcoholic beverages by young people may be from a technical point of view illicit or illegal but the reality is—I mean young people know it very well—that alcohol is a very important and culturally integrated part of American society. Therefore, your educational program is quite different.

Cocaine, heroin, marijuana, may be used much more than you would like to see them used in this country, but they are not at this stage culturally integrated. You are dealing with marginal behavior whereas with respect to alcohol, you are not dealing with marginal behavior; you are dealing with something that most people quite like to do.

Chairman **Glenn**. We are having a minor debate in this country—I think it is very minor, no one is very seriously considering it—but we see articles written about it every once in a while, about whether we should legalize some of the drugs that we now have listed as illegal. The British have taken a little different tack on that than we have. Do you have any thoughts on that, quite apart from the alcohol?

Dr. GRANT. Well, I am sure that if you are going to do that, what you should do is you should review all drugs and you might find that there were some substances currently illicit that you might wish to make more widely available, but perhaps some substances currently licit whose health damage is so considerable that you might want to review their status with respect to availability. If you are going to do this, you do it for all drugs, not just a few.

Chairman GLENN. That was a very diplomatic.

One other area I wanted to get into here, that you have listed even further down. You have your four top priorities. Then we go into education. Then you have what I termed in my own notes here as secondary/other considerations we might want to do, and you have other restrictions on distribution, which might be done. And then clear down in this about third tier down you have regulation of advertising, which surprised me a little bit that it was that low.

Now, I stayed up late last night doing some of this and also watching the Olympics. And the Olympics would not be on the air were it not for the alcohol advertising. That overstates it a little bit, but not a whole lot.

You almost got the impression that as Gregg Louganis going after his fourth gold medal last night, he could not have done it until he had a couple of beers before he went and one before and after, because the advertising came directly before and directly after. And I am sure the companies involved with that advertising fought to get those positions right there with all the implication that that has.

Now, maybe that overstates it a little bit, too, but not a whole lot, I don't think.

So you have downgraded the regulation of advertising quite a ways down here in your hierarchy of priorities here.

Is this just not effective in other parts of the world as you have seen it? Has there been restriction? For instance, we do not have any hard liquor advertising on here now. I do not know whether we can show a correlation between when that stopped on TV and what the consumption has been. Maybe there is little or no correlation.

What has been the experience in other countries? Have there been efforts to regulate advertising, and what is the effect of it?

Dr. GRANT. Well, as I said, this is an area in which the evidence is very mixed. There certainly have been studies that have shown the kind of correlation you are seeking. But there have been other studies which do not and the authors of the first category of studies criticized the others for methodological point of view and the authors of the second criticized the first. It is a very mixed, very muddy area.

Perhaps it is more mixed and more muddy because there are so many interests involved. One need not perhaps be too cynical to say that. But nonetheless, it is clear. And there is one study that I quote in the written testimony which comes to the conclusion that it is just as likely that increased sales will stimulate advertising expenditures and that advertising will stimulate sales. In other words, you are looking for a chicken and an egg. It is not real clear which is which.

Now, that doesn't mean, however, that it would be inappropriate to take action in this area, because it is a very, very visible area. Any restrictions which occur on the advertising and promotion of alcoholic beverages certainly have an immediate impact upon the environment and upon the way people perceive alcoholic beverages.

I would suggest, though, that if you are considering action in this area, that you do not limit it simply to billboard advertising or television advertising. In the first instance, there is the issue of promotion. You mentioned sports promotion. There is also cultural promotion. Promotional activities account for an increasingly large proportion of the expenditure of alcohol beverage industries.

Third, the question beyond advertising itself of the way in which drinking is portrayed in the media. Advertising reflects—advertising does not create a climate of opinion, it reflects a climate of opinion that is there, and that climate is there in part because of the way in which drinking is portrayed in the media.

My suggestion would be that if indeed this is an area which you think is worth taking action, that you insure that that action is taken on a broad rather than on a narrow basis. It may be that if it is done on that basis, it will be possible to carry the beverage industry with you rather than to find yourself fighting against the beverage industry. And there certainly are good reasons to suppose that that means that you might find you had friends where you might otherwise have had enemies.

Chairman GLENN. Well, I do not want to get this into a debate here this morning necessarily, but I think we could debate the effectiveness of advertising for a long time here this morning.

I think you have some companies that set out to really create a market. Now, the climate cannot be anti-market necessarily and overcome a tremendous hurdle there, although that can be done sometimes, too.

But these companies aren't out there spending $1.3 to $2 billion a year or whatever the figure is unless they know that it is expanding their market and it is doing a good job and they can see the advertising go on the air and they see the result in sales and it is there and it is a positive correlation and it just runs exactly like that.

Out of my checkered past at one time I was president of an international corporation dealing with soft drinks. I did not get involved in the advertising or anything like that. I was a company executive and I got into all this marketing business very, very thoroughly, not only in this country but around the world. And your advertising budget you put back into that is what determines your sales.

That was in a soft drink area but I think probably if you looked into it, I think the beer, wine advertising, the way they look at it, they can show their sales correlation go right along with their advertising. Now, you cannot take something that is obviously looked at as an absolute no, no, against the law, whatever, put it out and advertise it and sell that, necessarily, but something that is at least acceptable like beer and so on, I think you could show an absolute correlation between the advertising and the attractiveness of the advertising and whether it is appealing to a person at home.

I think you could show a perfect correlation between that and their sales.

Dr. **Grant**. Well, maybe in that case what you should consider is that you are dealing here with the advertising of a very special and hazardous product and that in considering what kind of advertising, if any, you would wish to permit, you should consider it in relation to the advertising that you permit for other products which are hazardous.

Chairman **Glenn**. Well, that is right, and so long as we have legal products, then it is very difficult to restrict advertising. You are getting into all sorts of constitutionality problems which those companies bring up and First Amendment rights, and you get into a whole host of things that we are all familiar with in this country, and so it makes it difficult to take that approach to it.

But I was surprised that on your list of things that has worked internationally that that would be listed sort of third-tier down as being effective.

Dr. **Grant**. Well, bear in mind, these are not in order of effectiveness. I am judging these in order of what the scientific evidence would allow one to say unequivocally about them. It may be that this indeed is a spectacularly effective mechanism but simply the evidence is not currently available to support that, either because the research has not been good enough or because research showing the opposite has also been funded. So I think that it is worth making that point.

Chairman **Glenn**. Let me just get one other question in here, too. Another one that even ranked farther down, I guess we would say was fourth-tier down, for which there was no real evidence, and I do not question your ranking of these things at all, but it is one that has received quite a bit of note in this country in the last year or so with the publication of the little book, "Adult Children of Alcoholics," and the effect this has and all of the different things that go into that.

It is quite a book. I have read that and looked at it and I thought it made some very good points.

You list down here, there was really no evidence that working with children of alcoholics really was an important part of controlling this whole problem. Yet, I think—I do not know the exact figures—but I remember seeing figures once that were rather staggering, that children of alcoholics tend to repeat the problem themselves to a very, very large extent. It is like 60 or 70 percent of the children of alcoholics in turn have problems themselves, and you probably have some figures to correct me there, but it was something of that order as I recall.

So it would seem to me that with us having in this country the experts estimate some 10 million alcoholics and another 8 million that are problem drinkers, that gives us 18 million people that have a real problem in this area and their children are going to probably grow up and repeat that, perhaps, and it would seem to me that is an area we could do more work in.

Has there been any work done with children of alcoholics in other countries any more extensively than has been done in this country with some of the publications we have had over the last couple of years that you are familiar with?

Dr. **Grant**. No. This country is certainly the country which leads the field in that area. I would just emphasize that I would agree with you. I think this is an immensely promising area. If one were to identify potential growth points for campaigns or initiatives or measures that might be undertaken, there is no doubt that the great advantage of this area is that it enables you to identify very quickly a highly at-risk population and therefore to design measures which might be targeted precisely at them.

I would think it was an immensely promising area but not one where there is as yet sufficient scientific evidence. I am familiar with the publication that you describe. I am familiar with the great deal of prominence that this movement has in this country at present. I am familiar, too, with the advances that are occurring currently in biomedical and genetic research.

For all these reasons I think this is an extremely promising area, but it would be really flying my own prejudices to push it higher up the list than it is at present. It remains an area of great promise but as yet unproven effectiveness.

Chairman GLENN. You have been very charitable with your time here this morning and I appreciate the time you are spending with us here and I have kept the questioning going here because these are areas of very great interest to me and to the Committee, so we do have to move on in a moment to our second panel.

Having said that, I lost my train of thought and forgot what I was going to ask, but there was one other question I had to ask and we will get back to you. Are you going to still be in the room a little while? I will think of it when we are on the next panel.

Dr. GRANT. I have to leave, I am afraid, to catch an airplane in about 20 minutes. But for those 20 minutes, I am entirely at your disposal.

Chairman GLENN. Good. Fine. Just one other question on this. You had as one of the items you listed last "Modify policy and social environment that when drinking occurs, other harmful consequences will not occur."

I did not quite follow that. What are you talking about there?

Dr. GRANT. Well, interest in a number of countries in research that shows that you can modify drinking environments so that people are either less likely actually to get drunk in them or if they do get drunk, they are less likely to harm themselves. You can, for example, discuss here issues to do with automobile design, with road design and so on. It is simply that if one accepts, as you did at the outset, a premise that what you are concerned with doing is reducing harm, there may be circumstances in which you can reduce the harm without reducing the amount of alcohol consumed.

Almost all the other measures we have talked about really are based on the presumption that by reducing the amount people drink you will reduce the harm. There are some circumstances where you can allow them to drink as much but reduce the likelihood of them harming themselves by having, for example, mechanisms in automobiles that prevent them starting up when they are intoxicated.

Chairman GLENN. I see.

Dr. GRANT. Or, for example, changing the nature of a bar so that you train the bar staff not to serve people who are so intoxicated that they are likely to damage themselves as they leave. There is a variety of strategies which have to do not so much with reducing consumption as with reducing the likelihood of harm following the intoxication consequent upon excessive consumption on a single occasion.

Chairman GLENN. Good. Thank you, Dr. Grant. We appreciate it very much. You have been very patient with us this morning. We want to keep in touch with you and if you come up with any brand new ideas or approaches you think we should know about, why, please take the initiative and call us or get in touch with us. We would appreciate it. Thank you very much for being here this morning.

Dr. GRANT. Thank you. I appreciate the opportunity for being here.

Chairman GLENN. Thank you.

Our next panel is on prevention policy, the legal approaches to it. We have a five-person panel here: Dr. Ralph Hingson, Boston University School of Public Health, Boston, Massachusetts; Dr. Philip Cook of Duke University, Durham, North Carolina; Ms. Patricia Taylor, Center for Science in the Public Interest, Washington, D.C.; Dr. Jean Kilbourne, Vice Chair, Council on Alcohol Policy, West Newton, Massachusetts; and Mr. John Burcham, Chairman of the Licensed Beverage Information Council of Washington, D.C.

I want to welcome all of you to our hearing this morning and we welcome your statements, even in a summarized version. We would prefer to have you give them that way so that we have as much time for questioning as possible.

In any event, though, whether you wish to give the full statement or the summarized version, the entire statement will be included in the record.

Dr. Hingson, would you lead off, please.

TESTIMONY OF RALPH W. HINGSON, SC.D., BOSTON UNIVERSITY SCHOOL OF PUBLIC HEALTH, BOSTON, MA [1]

Dr. HINGSON. Senator Glenn, I would like to thank you for inviting me to participate in this hearing and I applaud your interest in the problems that are posed by alcohol.

I was asked today to talk about some of the legislative reforms that have been directed at drunk driving. There is good news and bad news to report. From 1980 to 1985 there was progress made in the United States in the battle against drunk driving. Over 400 chapters of citizens groups concerned about the problem were founded, groups such as MADD, SADD and RID. Media attention on the issue as measured by numbers of news stories increased nationally. It increased 50-fold between 1980 and 1985; and there were over 500 legislative changes passed to reduce the drunk driving problem.

The legal drinking age of 21, as you know, became the national standard. Over 40 states adopted laws making it illegal per se to drive with a blood alcohol level of .10 or .08. That would be about 4 to 5 drinks on an empty stomach for someone my size. Almost half the states adopted administrative per se laws that permit licenses of arrested drivers to be held until their trial.

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[1] See p. 255 for Dr. Hingson's prepared statement.

During that same time period, from 1980 to 1985, accompanying all of this wave of legislation and citizen activity dealing with the drinking and driving problem, there was a substantial decline in fatal crashes. Fatal crashes declined 13 percent. There were 6,000 fewer in 1985 than in 1980. Single vehicle nighttime fatal crashes, the type that is most likely to involve alcohol, declined even more. They declined 20 percent. The declines were greatest nationwide among teenage drivers. Fatal crashes among teenage drivers were down 26 percent and the single vehicle night fatal crashes were down 34 percent. That is really a very remarkable achievement.

But unfortunately, studies of drunk driving legislation in other countries—in Great Britain, Canada, New Zealand and France—indicate that the benefits of drunk driving laws can be short-lived if publicity about laws erodes over time and the public becomes aware that police enforcement may not be as great as they orginally expected. I am concerned that we are seeing the first warning signs that this could happen here.

In the written testimony that I provided, in figures 2 through 5, there were graphs showing that the number of new citizen's groups dealing with the drunk driving problem peaked in 1983 and formation of new groups has dropped off since then. The numbers of news stories dealing with the problem also peaked in 1983 and it has been dropping since 1984, and in 1986 after several years of decline, single vehicle night fatal crashes—those most likely to involve alcohol—rose 7 percent, nearly 2,000 more in 1986 than in 1985.

Among teenagers, this increase was even steeper. Single vehicle night fatal crashes rose 17 percent whereas other fatal crashes rose only 6 percent.

Our projections are very similar to the projections of the Department of Transportation that indicated alcohol-related fatalities which had been declining for several years, rose 7 percent in 1986 relative to 1985 and 14 percent among teenagers in 1986 relative to 1985. The 1987 figures are only slightly better. Single vehicle night fatal crashes remained 5 percent higher than they were in 1985 and among teenagers, 9 to 10 percent higher than they were in 1985.

Though we should take these warning signs seriously, I do not believe it is inevitable that the remarkable progress that was made in the early 1980s has to decay. There are several steps that I think we should take to prevent a resurgence of the drunk driving problem. First, we need to refocus media and community attention on the problem. That the greatest declines in the early 1980s occurred among teenagers and also that the greatest increases since 1985 in drunk driving crashes have occurred among teenagers underlies the importance of constantly keeping public attention on the issue.

Every year new cohorts of teenagers enter the high risk driving pool and it is quite possible that today's teenagers weren't paying attention to all of the media attention that surrounded the passage of laws during the early 1980s.

Second, we need to increase police enforcement of the drunk driving laws we now have in place. During the 1980s we annually conducted several telephone surveys of drivers throughout the New England area, asking them how often they drive after drinking and heavy drinking and their perceptions of and contact with police drunk driving enforcement.

These surveys revealed that while arrests increased during the 1980s, there are still only three drunk driving arrests per thousand drunk driving trips that the respondents told us that they had engaged in. The risk of being arrested was no higher than the risk of being involved in a crash.

I think we have to ask ourselves is three arrests per thousand drunk driving trips adequate to deter drunk driving and what can be done to increase our enforcement. Certainly it will require more financial sources, but I think we also need more public support for the police efforts. We need to persuade the public that police enforcement is an effective public service. There have been numerous studies that show that when police enforcement is increased on this problem that the fatal crashes go down. And we need to convince the public that when conducted appropriately, police enforcement is not an infringement on personal liberty, it is a public service.

Third, we need to maintain or increase enforcement of laws targeting risky traffic behaviors more prevalent among drunk drivers. Our surveys found that persons who report driving after five or more drinks at least weekly were more likely than those who never did to say that they engage in a whole variety of other risky behaviors in traffic. These drunk drivers were 10 times more likely than other drivers to say that they drive after marijuana use or other drug use; twice as likely to report that they speed or ran red lights in the past week; one quarter as likely to wear safety belts; not too surprisingly, they were four times more likely to have been arrested in the previous year for traffic violations other than drunk driving; and they were five times more likely to have been involved in a crash resulting in injury.

Maine was one of the first States in the United States to pass comprehensive drunk driving legislation and my office undertook an indepth study of the effects of Maine's law in 1981. During the first year of that law, single vehicle night fatal crashes declined by one-third, much greater than any of the other New England States. But by the third year after the law, fatal crashes had returned to pre-law levels.

One reason, I believe, was that police attention to speeding enforcement during the post-law period was relaxed. During the first 3 years of the law, State police speed arrests declined by one-third in Maine and the proportion of speeders going over 65 on 55 roads almost doubled.

When I informed Governor Brennan of this, he acted immediately and instituted a speeding crackdown in 1985. Speeding arrests were increased by a third; fatal crashes went down 16 percent, which was more than in any other New England State, and declines were greatest among the night fatal crashes most likely to involve alcohol.

I am afraid that Maine's experience may foretell an ensuing national problem. In 1987, 38 States raised their speed limits on rural interstates, and according to the U.S. Department of Transportation in the first 6 months of those laws, fatal crashes on rural interstates rose 23 percent, whereas in the same States on the urban interstates where the speed limits had remained the same, there was a 13 percent decline and a 5 percent decline on other roadways in those states.

We did a further analysis of those data and we found that on rural interstates where the speed limit was increased, the number of fatally injured intoxicated drivers rose 47 percent and the number of people killed in those crashes with intoxicated drivers rose 43 percent. In contrast the numbers of drunk driving deaths did not increase on other roadways in the same States where the speed limits were not raised.

If you stop to think about it, drunk drivers, because of their slower reaction time and poorer sensory motor coordination are particularly dangerous as traffic speeds increase. It makes no sense to me to heighten enforcement of our drunk driving laws and to pass safety belt legislation and at the same time for us to be relaxing our speed laws.

Finally, we need to implement or improve educational efforts that stimulate informal social pressure not to drive drunk. Even if we doubled police enforcement, drunk drivers would still have more contact with their families and their friends than they do with the police. Many States experienced drunk driving and fatal crash declines even before new laws were passed in their States, suggesting that public discussion of the problem creates informal pressure not to drive drunk.

Substantial progress could be made, I believe, if we encouraged people not to ride with drunk drivers. Every year nearly 4,000 people are killed in crashes with drunk drivers who are passengers in those cars other than the drunk driver, so they are passengers in the same car with the drunk driver.

It seems to me that if a person is willing to get into a car with a drunk driver, that is almost providing tacit approval of the drinking and driving behavior.

So in sum, the legal changes that in the early 1960s undoubtedly helped to produce marked progress against drunk driving, in part, through legal deterrence and in part by focusing public attention on the problem.

However, legal changes by themselves will not sustain optimal declines. We need to back up these laws with strong educational and enforcement programs and we need to design our efforts to involve not only Federal and State governments, but encourage grassroots public and private sector attention to the drunk driving problem. We must also not relax our attention to other risky traffic behaviors more common among drunk drivers such as speeding or failure to wear belts.

Traffic crashes, as you pointed out, remain the leading cause of death among other nation's youth and nearly half the traffic fatalities continue to involve a driver or pedestrian who has been drinking. We should applaud the progress that was made in combating this problem in the early 1980s. We shouldn't let the progress that we encountered mislead us into complacency.

Chairman GLENN. Thank you, Dr. Hingson. Dr. Philip Cook is from Duke University, Durham, North Carolina.

Dr. Cook, I understand you have a time problem and you have to leave here before too long. We will have your testimony and then I will ask you some questions here so you will be free to leave. I was not aware you were going to have that. I am sorry. I was just told about that a few minutes ago.

TESTIMONY OF PHILIP J. COOK, PH.D., DUKE UNIVERSITY, DURHAM, NC[1]

Dr. COOK. Thank you, Senator Glenn.

As you noted in your opening remarks, excessive alcohol consumption poses a major public health problem and many factors influence the magnitude of this public health problem. But one factor in particular deserves special attention in any discussion of prevention and that factor is the price of alcoholic beverages.

The average price of alcoholic beverages in the United States has been declining over the years relative to the overall price level and in fact, adjusted for inflation, the average drink costs 28 percent less today than it did 20 years ago.

Falling prices encourage consumption and they encourage abuse. Falling prices have resulted in substantially more highway deaths, cirrhosis deaths, accidental injuries, absenteeism on the job, medical costs, and neglect of family responsibilities than if some means had been found to keep alcohol prices in line with the overall price level.

So why have prices declined? One reason certainly is that State and Federal taxes on alcoholic beverages have not kept pace with inflation. Most important in this respect is the Federal liquor tax, which, since 1951 has been increased just 19 percent, during a period when the overall price level increased over 300 percent.

In effect, then, the excise tax levels of the 1950s have been repealed by the inflation of the 1970s. Let me explain how I came to believe that the prices of alcoholic beverages have an important effect on the prevalence of alcohol abuse.

The most reliable type of evidence on the effectiveness of interventions of this sort would be generated by experiments conducted in the form of randomized field trials and, of course, it is not possible to perform a randomized experiment on this issue because this would require that a randomly selected sample of jurisdictions agreed to raise their taxes while other jurisdictions agreed to leave them unchanged. But if we could perform that experiment, as I say, it would provide the most reliable evidence.

Well, as it has turned out, something close to this experiment has, in effect, been performed by the State legislatures. Now, I looked at the period 1960 to 1975, during which time there were 39 instances in which the license states increased their excise tax on liquor. There was no particular pattern to those increases, so for all intents and purposes, they can be considered random.

In effect, then, we had a series of more or less random increases in the tax rate and a chance to study the effect of small changes in taxes. What I found was that in most of these instances the states that increased their tax experienced a reduction in consumption, cirrhosis mortality and highway fatality compared to other states in that year.

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[1] See p. 274 for Dr. Cook's prepared statement.

To my mind, this is strong evidence that price has a direct effect on heavy drinkers and on alcohol abuse and that even a small increase in the tax will have some preventive effect.

Now, to be specific, based on my results, I would say that a $1 increase in the Federal liquor tax at this time would reduce the cirrhosis mortality rate by about 1.5 percent; doubling of this tax would save over 5,000 lives each year just from cirrhosis mortality alone.

Chairman GLENN. One dollar on what amount or what? Per bottle or per what? Would this be a percentage increase over the existing price? Or how would you base that? Alcohol content?

Dr. COOK. One dollar per proof gallon. Currently the Federal tax is $12.50 per proof gallon, so it would be $1 in addition to that.

Chairman GLENN. And give your figures on what you feel that would save again, please.

Dr. COOK. A $1 increase over the current $12.50 would reduce cirrhosis mortality by about 1.5 percent. If you doubled it—that is, if you added $12.50 to the current Federal excise tax on liquor, then we are talking about something on the order of 20 percent, more than 5,000 lives, just from cirrhosis mortality.

To the extent that cirrhosis mortality is an indicator of other sorts of alcohol abuse and alcoholism, then presumably you also are going to reduce social costs from those other sources as well.

Now, using similar methods to what I have described, other economists have demonstrated convincingly that an increase in the excise tax on beer has the effect of reducing highway fatalities, especially highway fatalities in accidents involving youthful drivers.

The conclusion, then, to put it very briefly, is that leaving alcohol taxes unchanged in inflationary times provides an economic stimulus to alcohol consumption and abuse. With one rather minor exception, Congress has left alcohol taxes alone for 37 years now. Unfortunately, that failure to act on taxes is undermining all prevention efforts.

Thank you.

Chairman GLENN. Thank you very much, Dr. Cook.

Those are very interesting figures on what your estimates would be there. There are two things here. One is taxing for revenue and another is taxing for control of consumption. Now, you gave what you thought was a figure—you gave your figure there and what a $1 increase would be on hard liquor consumption and the effect that that would have on reduction in cirrhosis, liver deaths; eventually saving 5,000 lives per year.

Is this a straight-line function? Let's say we get up instead from $12.50 or whatever it is now, we go up $1, $2, $3, $4, on up, let's say to an additional $10 per proof gallon, just to take an extreme example. Is that same kind of reduction observed? Or what is the elasticity in the demand curve here? Is this going to taper off someplace?

Dr. COOK. The function that I was using was logarithmic in form so that the built in assumption is that each additional dollar has the same proportionate effect on the cirrhosis mortality rate.

I can't claim that that function is reliable for extreme changes. I was estimating it for a range of rather narrow changes associated with what we were seeing in State tax policy during that period.

Chairman GLENN. We have a Federal tax, of course, and some States have their own taxes, and those vary quite widely. Did you look at that as to the difference in alcohol consumption or in the hard liquor consumption from one State to another where a State has imposed a much higher tax than another State might, because when a person walks in the store and is considering buying, if price is important, that would vary quite widely from one State to another.

Do the consumption patterns follow that difference in price?

Dr. COOK. My concern was certainly at the State level. That is the level of the data that I was using. But I was more interested in seeing what was going to happen in response to a change in the State excise tax rather than doing a comparison across States at any given point in time. I was looking at what would happen in a specific State in response to a change in the excise tax.

The reason I looked at a number of changes, rather than comparing consumption levels in a single year, is because I find a comparison at a single point in time across States less persuasive and more difficult to interpret. If you use that sort of evidence, then you are always challenged with the problem of taking other things into account.

The States differ very widely in terms of traditional drinking practices and level of drinking and for reasons that include ethnic background and level of urbanization and many other things. I find no satisfactory way of controlling for all these factors. For that reason, I looked at changes in particular States rather than this cross section.

Chairman GLENN. Some people have suggested taxing all alcoholic beverages relative to their alcoholic content. Do you think that would be effective or is that a non-starter?

Dr. COOK. Well, I do not know whether it is a non-starter politically. I think that the argument in favor of taxing beer and wine in proportion to alcoholic content just as we do tax liquor, is that the active ingredient is the same in all cases, namely ethanol, and ethanol is the problem.

It is just as much of a problem in the more dilute forms as it is in liquor. And so, as a first cut, a tax policy that took account of ethanol content strikes me as very sensible.

Now, I am not sure that that is the best of all possible tax policies, but certainly the one we have right now isn't either.

Chairman GLENN. Did you break this down any on what the price impact would be on different people within our societal spectrum? In other words, would this have any effect on underage youth, for instance, as opposed to the adult working person as opposed to the elderly? Did you break it down in that way?

Dr. COOK. The type of beverage you choose to tax, of course, has different effects on different age groups and different groups within the society. Beer remains the overwhelming choice of youthful drinkers, so a tax on beer has a disproportionate effect on youthful drinking and the consequences of youthful drinking. If you are talking about liquor, then you are talking about an older age group, so that there certainly is that well-known distinction.

Chairman GLENN. Did you track back in any of your studies as to what the price increase and decreased consumption would have on agricultural products used in the manufacture of beer or wine or hard liquor?

Dr. COOK. No, I haven't done that.

Chairman GLENN. Is it a secondary effect that goes back here. Let's say the French, for instance, had had a 27 percent reduction. Now, that translates back into—I presume, into quite a percentage of decreased income for people that were supplying the agricultural products for the beverages.

Have there been any studies done on that? Do you know? I presume someone has done some studies on that.

Dr. COOK. And I am not one of the ones that have done one, so I can't help you about that.

Chairman GLENN. Does anyone else know? Do any of the rest of you have any questions you want to ask of Dr. Cook? I know he said about 11:40 was his last get-out time here. We are right at that. I believe he has an airplane to catch or something here. Are there any questions any of the rest of you have of him before he leaves?

[No response.]

Chairman GLENN. Dr. Cook, thank you. We may want to address some different questions to you from the Committee members that were not here, or staff. We hope you would answer those so that could be included as part of our hearing this morning.

Dr. COOK. I would be happy to do that.

Chairman GLENN. Thank you very much for being with us this morning.

Ms. Patricia Taylor, Center for Science in the Public Interest, Washington, D.C. Ms. Taylor, welcome this morning; we look forward to your testimony.

TESTIMONY OF PATRICIA TAYLOR, CENTER FOR SCIENCE IN THE PUBLIC INTEREST, WASHINGTON, DC [1]

Ms. TAYLOR. Thank you, Senator Glenn.

First of all, I would like to thank you and your Committee for holding these hearings. Just as alcohol is the neglected stepchild in the national debate on how best to wage a war on drugs, prevention policies are the black sheep of the Federal alcohol effort. We welcome your interest in this area and hope that after your review of the testimony you will conclude that we really must take steps and act to implement serious, coordinated, comprehensive prevention policies.

I have been asked to testify about warning labels, a simple, straightforward way to inform consumers about the health and safety risks associated with the use of alcoholic beverages. Unfortunately, the history of attempts to require these labels is not so simple.

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[1] See p. 286 Ms. Taylor's prepared statement.

In 1977, as Senator Thurmond testified earlier, then Food and Drug Administration Commissioner Donald Kennedy informed the Treasury Department's Bureau of Alcohol, Tobacco and Firearms that he thought health warning labels were needed to inform consumers about the effects of drinking during pregnancy. Over 10 years later alcoholic beverages still carry no health and safety warning labels, although there are a few exceptions.

As you mentioned, wine coolers made with saccharin must carry the FDA-required saccharin warning. Champagne bottles have corks bearing a warning about how to prevent eye injuries when opening the bottle. But there are no warnings concerning alcohol.

In 1979 Congress asked the Departments of the Treasury and Health, Education and Welfare, to produce a report on actions that should be taken to inform the public about health hazards, including birth defects associated with alcoholic beverages.

The report was delayed and not released until November 1980 shortly after the election of President Reagan. It rejected health warning labels but was accompanied by an unusual White House disclaimer expressing disagreement with its conclusion. Instead of labels, a series of Federal and private sector strategies were recommended to educate the public, few of which have been implemented to date.

In 1981 the Surgeon General issued an advisory which alerted women who are pregnant or even considering pregnancy to abstain from drinking because of the risk to the unborn of mental retardation and birth defects.

At the Congressional level, attention to alcohol warning labels began in 1969 when Senator Thurmond introduced the first health and safety warning label bill. As Senator Thurmond mentioned, there has been a long history of Congressional consideration of these labels. Most recently, in 1986, a report was required by the Department of Health and Human Services on the effectiveness of health and safety warning labels as part of the Omnibus Drug bill.

When the Department of Health and Human Services concluded its report, they sent it to Congress and to the Bureau of Alcohol, Tobacco and Firearms where yet another study was underway.

This study was scheduled for release last January. The report is now due shortly after this year's Presidential elections, almost 8 years to the date of the last BATF study on warning labels. At hearings on alcohol labeling held in August by the Senate Commerce Committee's Consumer Subcommittee, William Drake, Assistant Director of BATF, read a statement requesting that Congress hold off on any legislative action until the Bureau of Alcohol, Tobacco and Firearms concludes its latest study on consumer attitudes on labels. The day of his statement, the Washington Post reported that the Office of Management and Budget had cleared the BATF testimony favoring warning labels. The action was reversed after the beverage industry learned of the decision and, according to the Post, an internal fight at the White House.

The history of this issue clearly demonstrates how Federal assignment of regulatory authority over alcohol has hampered efforts to educate the public about alcohol. Regulation is left primarily to the Treasury Department, an agency whose main intent and responsibility is the collection of Federal taxes. Alcoholic beverages are in a class by themselves being exempt from traditional consumer information programs for all foods and drugs except tobacco and from regulation by the agency charged with protecting the public health, the Department of Health and Human Services.

The history of efforts to require warning labels exemplifies what the alcoholic beverage industry has come to know and to rely on, that the Treasury Department's Bureau of Alcohol, Tobacco and Firearms does not have as its mission or its expertise the development of policies that would protect the public health.

According to the Department of Health and Human Service's 1987 report, consumer information campaigns are especially important in conjunction with legislative and regulatory efforts such as requiring warning labels. Americans' perception of risks are often inaccurate and when it comes to alcohol, the most used and misused drug in our country, the absence of consumers information on labels denies consumers the information necessary to properly assess the risks of drinking.

It also implies by omission an assurance from the Federal Government that all alcoholic beverages are safe for consumers at all times.

Over the last 5 years a growing number of cities, counties and States have been enacting legislation requiring the posting of signs, for example, wherever alcoholic beverages are sold that warn about the dangers of drinking during pregnancy. These campaigns have not been supported by alcohol producers. Even the simple educational device of a warning poster which affects retailers, restaurants and bars has been opposed.

For example, under California's Proposition 65, the State's Scientific Advisory Panel declared alcohol to be a reproductive toxin. In response, that State's Health and Welfare Board announced that effective October 1 of this year warning posters informing consumers about the dangers of drinking during pregnancy would be required in all of the 68,000 licensed alcohol outlets in that State.

While consumer and public health organizations have petitioned for warning labels as the more effective way to inform consumers, the alcoholic beverage industry opposes even the poster requirement and has been fighting its implementation.

Educational campaigns about the risks of drinking during pregnancy, drinking and driving, and drinking while taking other drugs have been undertaken by many non-profit organizations and local State and Federal governmental agencies, but the over 100 national and State organizations which Senator Thurmond mentioned to you earlier endorse Federal health and safety warning label legislation this year.

These educational campaigns simply are not enough. These organizations advocated adoption of one of the simplest public health educational tools available to alert consumers about the effects of alcohol—health and safety warnings on each container of beer, wine, hard liquor or wine coolers sold in the United States.

The vast majority of Americans simply do not know and do not have access to the information they need to decide when, and when not, to drink. The desire for information about alcohol is reflected in the strong public support for measures like health and safety warning labels. In the most recent public opinion poll conducted by

George Gallup in 1986, 80 percent of those surveyed supported warning labels.

The many organizations supporting Federal warning label legislation view the labeling of alcoholic beverages with specific health messages as an important component of a comprehensive strategy to address alcohol-related problems and alcoholism in our country. While I am testifying on behalf of the Center for Science in the Public Interest today, I have also attached a copy of the organizations endorsing Federal warning label legislation with my testimony.

In July of this year, Surgeon General Koop issued the Surgeon General's Report on Nutrition and Health. That report, which has been criticized for its lack of specificity regarding recommendations for Americans to follow in their diet to reduce intake of fats and cholesterol, sodium and weight control, was specific in one area, alcohol, and I quote from his recommendation: "To reduce the risk for chronic disease, take alcohol only in moderation, no more than two drinks a day, if at all. Avoid drinking any alcohol before or while driving, operating machinery, taking medication, or engaging in any activity requiring judgment. Avoid drinking alcohol while pregnant."

The Surgeon General went on to explain that alcohol is a drug that can produce addiction and has been associated with disruptive family functioning, suicides, homicides, as well as liver disease, stroke, high blood pressure and some types of cancer.

Under bills introduced in this session of Congress, all alcoholic beverages would be labeled to cover the proven health risks the Surgeon General identified in his report. On August 10 at the Senate Commerce Committee's Consumer Subcommittee hearings on one of those bills, S. 2047, which we are grateful to you, Senator Glenn, for cosponsoring, the National Council on Alcoholism testified on behalf of the coalition and I would like to enter, if I may, that testimony for the record.[1]

Chairman GLENN. Thank you.

Ms. TAYLOR. At those hearings, panels of prominent physicians and researchers in the field of alcoholism testified about the need for health warning labels. Absent from the hearings were any representatives of the alcoholic beverage industry who had been invited to testify but chose not to attend.

As Senator Thurmond has described, the bill that was proposed, S. 2047, at that time required five labels that would rotate about five specific health risks. Lined up in opposition to rotating health warning labels has been the alcoholic beverage industry. This powerful lobby doesn't want consumers to associate drinking with mental retardation and death on the highways, although they do sponsor occasional ads to remind us to drink moderately, whatever that might mean.

Until now, the industry had successfully held off action on warning labels but the health conditions continue to pile up. Alcohol producers have argued that labels stigmatize light to moderate drinking as being unsafe. They believe this is misleading since they want consumers and policymakers to believe that it is only excessive drinking that is harmful. Pregnant women have been advised by the Surgeon General not to drink at all.

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[1] The information referred has been retained in the Committee files.

Anti-drinking and driving campaigns sponsored by citizen organizations, insurance companies and the alcoholic beverage industry promote the use of designated drivers. That is because if you are going to be driving or sailing a boat or using dangerous machinery, you should avoid drinking. But these campaigns also carry a very subtle disturbing second massage, that if you are not the designated driver you can drink heavily.

Opponents have also argued that labels will injure the credibility of the Government. Unfortunately, the Federal Government has ignored alcohol to such a degree that even the most basic proven techniques to inform consumers about alcohol have not been implemented.

Last week the Senate Commerce Committee unanimously approved a compromise warning label bill. After rebuffing an offer by Senator Orrin Hatch to negotiate a compromise bill last spring, after refusing to testify before the Senate Commerce Committee, and after the pressure generated by warning and supports has mounted, the alcoholic beverage industry, acting through Senator Wendell Ford, agreed to a compromise warning bill.

This bill would require one label on all alcoholic beverage containers; that label would read:

> According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects. Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery and may cause health problems.

It has been over 10 years since FDA Commissioner Kennedy first recommended warning labels about the dangers of drinking during pregnancy. We believe S. 2047, if enacted, would represent a tremendous victory for American consumers. Warning labels on alcoholic beverages are long overdue. Of course, the compromise bill does not do everything we had hoped to accomplish.

We are concerned with the fact that the bill would preempt States from requiring their own warnings, especially because some of the specific health risks identified by the Surgeon General and contained in the original bill are no longer mentioned.

We are also concerned that the proposed label speaks of other health risks without identifying what they are. But despite these reservations, we believe that S. 2047 will make an important contribution to informing consumers about some of the specific, proven risks associated with drinking and look forward to its enactment this year.

Of course, health warning labels on alcohol will not reduce or eliminate all alcohol-related problems. They are only one part of a far more comprehensive effort we must commit ourselves to to prevent needless alcohol-related tragedies. There is much more that needs to be done. There are many other activities that the Federal Government could undertake to assume a much needed active role in fighting alcohol-related problems. The Department of Health and Human Services should become the lead regulatory agency for alcoholic beverages.

When HHS Secretary Bowen announced his first national initiative on alcohol abuse and alcoholism last fall, we, frankly, were disappointed. Many of his recommendations involved simply discussing public health initiatives with other Federal agencies in the hope that they would be convinced to take action.

Alcohol problems are far too grave to be left to such a regulatory system. The present Federal efforts overseeing alcohol policies is severely flawed. Unless priorities are changed, effective prevention programs will suffer from further neglect. The present system of Federal regulation of alcoholic beverages has denied consumers far more than health and safety warning labels.

Senator Glenn, as you know, the alcoholic beverage industry is very powerful. It is using every resource at its command to convince consumers and elected officials that alcoholism, drinking and driving fatalities, mental retardation and the dismaying list of other alcohol-related tragedies have nothing to do with their products or how they are promoted. We hope that Congress will have the ability to stand up to that industry and pass legislation that most members know is desperately needed.

I appreciate the opportunity to come before you today and thank you for your interest and welcome the opportunity to assist any way we can.

Chairman **Glenn**. Thank you very much, Ms. Taylor.

Next is Doctor of Education, Jean Kilbourne, Vice Chair, Council on Alcohol Policy, West Newton, Massachusetts.

Ms. Kilbourne welcome and we look forward to your statement.

TESTIMONY OF JEAN KILBOURNE, ED.D., VICE CHAIR, COUNCIL ON ALCOHOL POLICY, WEST NEWTON, MA [1]

Dr. **Kilbourne**. Thank you. It is a great pleasure to be here. I look forward to this opportunity.

As we have heard in many different places today, alcohol is our Nation's number 1 hard drug and the alcohol industry spends about $2 billion on advertising and promotion. As you mentioned yourself, the advertising budget for just one brand of beer is twice the budget for the NIAAA, so these are the kind of odds that we have been up against.

The alcohol industry claims that its only purpose with all of this advertising and promotion—its only purpose is to get drinkers to switch brands. Now, I think it is very obvious—certainly it is obvious to anyone, as you said, that has been in business—that one of the major purposes of advertising is to increase sales, increase consumption, and also to recruit new users. Also, all of the research on problems can be summed up in one sentence which is that as consumption increases, problems increase.

It is impossible to prove conclusively that advertising increases consumption, and the reasons for this are that the effects, of course, are long range and they are cumulative. They are often very difficult to measure, and there is no comparison group. There is no group in the society that has not been exposed to massive doses of advertising. The kinds of research that have been done typically have involved showing drinkers an ad and then offering them a drink and seeing if they will take it. It doesn't make sense. The real way to look at this, I think, is through social learning theory, that it is a powerful socializing force.

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[1] See p. 312 for Dr. Kilbourne's prepared statement.

Many of us feel that, given the problems associated with alcohol in our society, the burden of proof should be on the alcohol industry to demonstrate that advertising does not increase consumption, does not contribute to these problems. As an advertiser said in Advertising Age, "A strange world it is in which people spending millions on advertising must do their best to prove that advertising doesn't do very much." So there is a very different point of view here.

I do not think that we need to debate the effects of advertising on alcohol consumption. I think we need to regulate alcohol advertising, if for no other reason than the way in which alcohol ads inhibit honest discussion in the media of alcohol-related problems. There is what amounts to wide-spread censorship of this issue throughout the media, as well as the socializing factor, that alcohol ads create a climate in which unhealthy and sometimes dangerous attitudes about alcohol are presented as normal, appropriate, innocuous and in which alcohol is presented as only benign, and sometimes even as a magic potion that will transform your life.

The alcohol advertising contributes to the climate of denial that exists in this culture about the number 1 hard drug.

I think it is important in discussing alcohol advertising to use examples. I did prepare a short video tape which I understand I am not able to show—there isn't time to show it—but I am going to leave it. It is about 2½ minutes long and I hope you will have an opportunity to see it at some point.

I also was told I couldn't use a slide projector so I have gotten around this by bringing a human slide projector and some posters.

I am just going to show a few examples. This is Robert Shear, who is the former Director of the Division of Alcoholism and Alcohol Abuse from New York State and is currently with the Council on Alcohol Policy. I am also including a report of Bob's in my testimony. He has graciously offered to show just a few examples because I think it really is true that a picture is worth a thousand words. This one—a big ad for beer—says, "When you are feeling a quart low."

Now, it seems to me that anyone who is feeling a quart low has probably got a problem and certainly this plays upon the whole idea of alcohol as a drug, as an addiction, as something that you need. One of the major points of alcohol advertising is to target the heavy drinker and to convince that person and everyone around him or her that his or her drinking is normal and acceptable and they should not worry.

I think an extremely important statistic is that 10 percent of the drinking population in our country consumes over 60 percent of all the alcohol, and this corresponds very closely to the percentage of alcoholics in the society. If about 1 in 10 drinkers is alcoholic, then you can see that there is a very close correspondence here.

In other words, if alcoholics were to recover—and the only way an alcoholic can recover is to stop drinking entirely—if this were to happen to all 10, 12, 14 million alcoholics in our society, certainly the gross revenues of the alcohol industry would be cut in half. They could not possibly want this. As with any product, the heavy user is the best customer. When the product is a drug, the heavy user is almost always an addict. And I think that is a very important aspect of the climate that is presented in these ads.

The second one is an example of the sort of risky activities that are frequently in ads here. Here a young couple floating down a river on innertubes with another innertube filled with beer, cans of beer; certainly plenty for this outing.

We know that about 69 percent of all drownings are related to alcohol. Certainly you would not see an ad these days with a couple with this much beer in the back seat of their car and yet this is certainly as dangerous.

These ads make it appear that alcohol is completely benign and that there is no risk. These ads are particularly appealing to young people, and the research on alcohol advertising does indicate that alcohol advertising especially affects young people. Advertising in America is a powerful educational force. It sells more than products. It sells values; it sells attitudes. And certainly the research indicates that it has a great effect on young people. We hear a lot about how young people drink because of peer pressure, but this completely ignores how the peers themselves are socialized, where these attitudes come from.

I lecture on college campuses. I am on about 100 college campuses every year. We have seen in recent years the most aggressive marketing campaign in the history of advertising launched by the producers on these campuses. Bob has a couple of examples here clearly targeting college students. Here the Lite Beer "Wonderful College Roommate" poster. The students use these posters to decorate their dorm rooms. They are everywhere. The industry also, of course, promotes sports, sponsors sports events, spring break, wet T-shirt contests, all kinds of other things designed to teach the students that they need to drink heavily in order to have a good time.

The next one shows the dream dorm with the beer prominently in the window and outside all of the happy activities that are related to this.

Younger children are also being reached and targeted by these messages. As we heard earlier, by the time a student has graduated from high school in America, he or she will have seen 100,000 television commercials for beer. Television commercials reach 90 percent of all teenagers and 92 percent of all children every single week. The next example is a well known one, Spuds MacKenzie, an extremely popular advertising device from Anheuser-Busch, clearly aimed at very young people. Anheuser-Busch has licensed this image to toy manufacturers. There are T-shirts available in very small sizes. Sometimes Spuds appears in Santa Claus outfits, obviously appealing to very young kids.

The next one is another example of that, "Twist It, Sister," which is a play on words. There is a rock group called "Twisted Sister." You probably know this, Senator, but in case you do not—I didn't until recently—one of their hit songs was called "Smoking in the Boy's Room," which gives you some idea.

Chairman GLENN. Are you inferring I am not with it, with the hip generation or something? [Laughter.]

Dr. **Kilbourne**. I didn't get this myself until it was explained to me.

Chairman **Glenn**. I get it.

Dr. **Kilbourne**. I know you do. Twisted Sister. Anyway their hit song was called "Smoking in the Boy's Room," so I think that gives you some idea of the age group that this appeals to.

As we have heard, the average age at which kids begin drinking today is 12 and that 30 percent of fourth graders have experienced peer pressure to drink. Alcohol is involved in over half of all the major causes of death for young people—auto crashes, suicides, homicides, and also it is involved heavily with teenage pregnancy, with rape, with assault and many other kinds of problems that face our young people today.

And yet the ads continue to link alcohol with success, with maturity, with sophistication, with—as in the next example—athletics. And here we have active athletes from the NBA who are promoting Budweiser, which was, I thought, against the guidelines of the BATF. I have learned since that those regulations were proposed but not adopted to exclude active athletes from these ads.

And finally, of course, and throughout the media, sex is used to sell, and this is particularly appealing to young people. Many of the posters are extremely demeaning to women and very sexist.

Women and minorities are also heavily targeted by the alcohol industry and I am also including with this testimony a report from the Center for Science in the Public Interest on "Marketing Booze to Blacks".

There is also wide-spread media censorship. In just the past year we saw cover stories in four major magazines on alcohol—Time, News Week, People, U.S. News and World Report. This in itself was quite remarkable, to have this much coverage. However, in every issue of those magazines there were no alcohol ads whereas ordinarily there would be four or five.

How often can they afford to do this? Certainly not very often. The war on drugs, the media coverage of the war on drugs routinely eliminates the two major killers, which are alcohol and nicotine, and, of course, alcohol and cigarettes are the most heavily advertised products in the country.

I do not think we can get honest information from a media that depends upon the good will of the alcohol industry. We have to have some kind of regulation just to make information available.

The industry response is that, of course, they want people only to drink moderately, although in fact moderate drinking would devastate them. Sometimes they come up with campus programs designed to illustrate this. One Miller's campus program that I have seen defines moderate drinking as four drinks a day. Oftentimes it is this kind of thing, which looks all right. "What's a Buddy?" This was put out from Budweiser, and the idea is that you should not let your friends drive drunk.

Now, certainly the emphasis always is on not driving drunk. It is never on not getting drunk and never have I seen any of these campaigns where abstinence is a choice. It is always "Know When to Say When." It is never "Know When to Say No."

But further, this one says in fine print that when your friend has had too much of a good time, do not let him drive. I find that a very interesting way to describe being drunk and it seems to me that they are subliminally suggesting that in fact the drunker you are, the better the time you are having. So I feel that these programs are not what is needed. What is needed is a ban on alcohol advertising or strong counter ads that give people the other information.

We also certainly need a comprehensive national alcohol policy which requires Congressional action. We must stop the denial, the denial that alcohol advertising both perpetuates and depends upon, and I really thank this Committee for its good work in this direction.

Thank you.

Chairman GLENN. Thank you very much.

Our next witness is Mr. John Burcham, Chairman, Licensed Beverage Information Council, Washington, D.C.

Mr. Burcham, welcome to our hearing this morning.

TESTIMONY OF JOHN B. BURCHAM, JR., CHAIRMAN, LICENSED BEVERAGE INFORMATION COUNCIL, WASHINGTON, DC [1]

Mr. BURCHAM. Thank you very much, Mr. Chairman, and I thank you especially for this opportunity to report on the Licensed Beverage Information Council's support of extensive public education programs on alcoholism and other issues. I am John Burcham, the Chairman of that council.

Ten industry trade associations formed the Licensed Beverage Information Council in 1979 and pledged its cooperation with the U.S. Department of Health and Human Services and the U.S. Department of the Treasury.

These associations represent those who produce, import, distribute and sell beer, wine and spirits in this country. The LBIC is a 501(c) 3 tax-exempt educational organization. We are not a lobbying organization. We do not take positions on legislative proposals and I am not in a position to answer questions about legislative proposals.

Most people who drink do so responsibly. All of us in the alcohol beverage industry abhor any abuse of our products. This is the reason various industry associations and their members have supported programs aimed at reducing alcohol abuse and promoting responsible use since the repeal of national prohibition. These varied and extensive programs are documented in appendices to this statement, most of which was sent to the Committee back in June.

Chairman GLENN. Good. We will retain that material in the Committee files.

Mr. BURCHAM. There seems to be a misconception that the industry is not doing anything to encourage people to be responsible about drinking. I hope my testimony will set the record straight in this regard.

The LBIC public education efforts are directed to, one, help pioneer drinking and pregnancy research and education programs carried out by the Boston University School of Medicine; two, active involvement and cooperation in the Department of Health and Human Services and in the "Healthy Mothers, Healthy Babies" program; three, working with the Department of Transportation to help create a nationally known "Friends Do Not Let Friends Drive Drunk" program, a national billboard program done in cooperation with the Outdoor Advertising Association of America, which would have cost millions if purchased commercially; four, creating television and radio public service messages against drunk driving which were distributed via satellite by the National Association of Broadcasters and used by hundreds of stations around the country. This effort, too, would have cost millions had it been purchased; five, over a period of 10 years creating a network of organizations and individuals from a wide variety of specialties and disciplines to help in the area of alcoholism and alcohol abuse.

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[1] See p. 348 for Mr. Burcham's prepared statement.

These are just a few examples of some of the programs that we have undertaken. All of this and more appears in my 21-page written statement to this Committee which was accompanied by many exhibits which detail the work of the Council.

In conclusion, Mr. Chairman, let me say that I know of no industry which has spent as much time, money and energy in public education efforts as our industry has.

Thank you very much for this opportunity.

Chairman GLENN. Thank you very much.

Dr. Hingson, you have suggested several actions that need to be taken in order to sustain the progress made across the nation in reducing drunk driving and fatal vehicle crashes. What role do you think the Federal Government ought to play in this? We are dealing with a lot of State laws and driving laws and a whole bunch of things. What should be our role?

Dr. HINGSON. Well, I think the Federal Government can play several roles. First, I am a researcher and I am very interested in evaluating the effects of drunk driving legislation. I am concerned that not all states routinely test all drivers who are involved in fatal crashes.

In fact, only about three-quarters of them test all fatally injured drivers. Until we have more comprehensive testing of all drivers who are involved in fatal crashes, it is going to be very difficult to accurately assess the impact of different legislative approaches to deal with the problem. So I think, number 1, we need to increase testing. There have been improvements made in the 1980s but we need to move further in that direction.

Second, I think that the research efforts undertaken by the National Institute on Alcoholism and Alcohol Abuse and the U.S. Department of Transportation need to be further strengthened and supported. There certainly is much that we can learn from those kinds of efforts, not only from the point of view of what kinds of legislative actions with regard to specific penalties and changes in enforcement practices, but also how we can integrate legislative action with educational programs.

Currently in Massachusetts we are trying a comprehensive community-based program that will try and reinforce the drunk driving legislation that has recently been passed in our State that includes increased education in schools, increased public information for the general public, setting up community task forces to try and keep public attention focused on the problem, that will try to involve industry in the problem by having corporate drunk driving seat belt programs, and I think that there is a need for more evaluations of these kinds of programs and evaluations of comparisons of different enforcement strategies to see which will work best.

Chairman GLENN. How much of this decline in drunk driving fatalities between 1980 and 1985 was due, in your opinion, to the passage and active enforcement of drunk driving laws and how much to increased media attention that the drunk driving issue received in the early 1980s?

One sort of involves a juxtaposition of one of program and another. Will tougher laws do it? Or is it peer pressure and is it media? Is it making it unpopular with people to drink and drive drunk and all of that? Do they go together or is it one or the other or why did we have that reduction from 1980 to 1985?

Dr. HINGSON. It is not an either/or situation. In order to get laws passed there has to be education in order to persuade legislators that there is a need for a law and that certain types of legislative actions will work. There certainly have been studies that have looked at specific legislative interventions.

The studies of the drinking age changes typically indicate 10 to 15 percent decline in nighttime fatal crashes in states that passed those laws in the age groups that were targeted by the laws. There have been studies of the administrative per se laws, the criminal per se laws and increased penalties that compare states that passed these types of laws to those that did not. Those studies indicate roughly a 9 percent decrease in fatal crashes—nighttime fatal crashes—in States that passed administrative per se laws that can suspend the driver's license until trial, and about a 6 percent decline in those other kinds of legislative measures.

That is not to say, however, that the education in and of itself that precedes the legislation cannot have an impact. We have done studies in New England that indicate that there were—as the public was debating whether or not to pass new laws and was coming to believe that there was less enforcement than they wanted and less strict laws than they wanted, there were simultaneous declines going on in their driving after drinking, and when we asked respondents in surveys conducted annually prior to passage of these laws how they would feel if one of their friends found out that they had driven drunk, the proportion who said they would not care at all was cut in half, so that there was informal social pressure going on to reduce drunk driving even before the passage of the laws. It is not an either/or situation. Both laws and education, in my view, go hand in hand.

Chairman GLENN. I will address this to all of you here, and this is rather macabre, I guess, or something, but I will to lay it out here and see what you think of it.

Has anybody tried, with regard to punishment of drunk drivers, have they done anything like some of the judges every once in a while get fed up and force people that come before them on second offenses or third offenses to go visit the morgue and actually look at a body that is actually beat up in a drunk driving death? That is one.

Have you ever tried, or any of your people ever tried identifying or looked into putting an identifying symbol on an automobile of a person who has been convicted of drunk driving so it is not only the personal shame involved with that but it also tells law enforcement, watch out for this guy, or woman, whoever it may be. There are some things like that, that it seems to me would be very, very impressive on people if we followed some trails like that.

I know we get into some constitutionality questions here on identifying "Scarlet Letter-type" approaches to automobile identification and things like that.

Have you looked at things like that? Do you think that would be effective or non-effective or is that going too far?

Dr. HINGSON. Well, I think that with regard to the identification, certainly there ought to be an identification of licenses so that if the police stop a vehicle and ask the driver for a license, they will know whether or not they are dealing with a repeat offender or someone who has never been convicted of drunk driving before.

Maine this last year passed legislation that drivers who have been convicted of driving drunk who have their licenses after fines and reeducation and so on reinstated, receive a provisional license and the provisional license, the proviso is that they are not stopped driving after drinking that would get them up to a .05 level, rather than the .10 level which is the current standard in most States.

Chairman GLENN. By license, you mean their driver's license?

Dr. HINGSON. Their driver's license.

Chairman GLENN. That is not a public view of what is going on. It may be effective. I think most states have a notation on the driver's license but then if you get caught a second time where it is bad——

Dr. Kilbourne?

Dr. KILBOURNE. I have heard of people being sentenced to go through the morgue and also through rehab places where they see people with brain injuries and paraplegics and that sort of thing as a result of this. I have also heard about day-glow colored bumper stickers for cars identifying a driver.

I think that the most effective thing I have heard of, however, has been done by a Massachusetts judge named Al Kramer who sentences people in his court to—recognizing that the majority of people who are arrested for drunk driving do have serious problems with alcohol—rather than sentencing them to a 4-hour program or something, gives them a choice between going to jail or going to many AA meetings, and they have that choice, and he has had very good luck with getting people really into recovery, not simply into a very brief program.

Chairman GLENN. Ms. Taylor, do you have any comments?

Ms. TAYLOR. I believe there is an article that describes similar programs that I would be happy to submit for the record describing trips to the morgue and other similar programs.

Chairman GLENN. Have they been effective or not effective?

Ms. TAYLOR. I am sorry, I really do not know, but I would be happy to provide that information to you.[1]

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[1] See p. 370.

Chairman GLENN. It seems so easy to try out in some communities, it would be a very easy thing I would think, if somebody just followed through on it.

Mr. Burcham, do you have any comment on that?

Mr. BURCHAM. Senator, I have heard of such programs but I have heard nothing concerning any evaluation of the results so I really have no comment. It is out of my own element.

Chairman GLENN. It certainly would be simple enough to try it, it seems to me. I do not know why somebody hasn't pushed it a little bit further.

Ms. Taylor, on the warning labels, what has been the experience with cigarettes? Has there been follow-up psychological studies or whatever that show what really got people to start smoking fewer cigarettes and really start turning that off? Did the warning labels have any impact on it, or was that just one of a hundred different things that fed into it in addition to the Surgeon General's Report?

Ms. TAYLOR. A number of studies have been done on this. The Department of Health and Human Services' report to Congress last year reviewed the cigarette experience and their finding and other findings were that the health warning labels were an effective method, again, in beginning a debate.

I think what Dr. Grant was talking about this morning regarding alcohol has been demonstrated by our experience with tobacco. In a number of areas we have to implement policies and those policies bring about discussion, create an environment where we can actually take steps to prevent and change people's smoking habits and also, in this case, drinking habits, so that the warning labels on tobacco were effective. We have also taken other steps as far as tobacco is concerned.

We have been much more willing, for example, to implement price policy changes as far as tobacco is concerned than we have been with alcohol.

So the excise tax on cigarettes has gone up. There is no longer advertising of tobacco products on TV. There are warnings on billboards about dangers of smoking. We haven't taken any of those steps in the area of alcohol. What we need to do is see how we can put together an effort similar to what has been taking place with tobacco as far as alcohol is concerned.

Chairman GLENN. Dr. Kilbourne, do you think a ban in advertising—I'm not sure that would be legal so long as it is a legal drug—you advocate a ban on it. Is there any better way of controlling it than just a ban?

Dr. KILBOURNE. Well, I said that some people were calling for a ban and some increased counter-advertising. I think in terms of the legality, that is a gray area, but, as you know, the First Amendment doesn't necessarily protect commercial speech and the Puerto Rican gambling situation was one that seems to be related to this as well where gambling is legal there but is not allowed to be advertised. So there is some precedent for that.

Personally, however, I really favor counter-ads because I think that they can be very effective and in fact, speaking from the tobacco experience, we do know that counter-ads made a big difference in affecting cigarette consumption. I think counter-ads give a real opportunity then to get this information across and also would have some impact on the willingness of the media to discuss these issues more openly.

So that is personally what I favor. There are some people who favor balance. I do think that there should be tremendous restriction on the advertising that is aimed at young people. There should be something really done about college promotions, for example, and the ads that are clearly aimed at very young people.

Chairman GLENN. You also suggested that Congress should consider the transfer of authority over beverage alcohol products from the Bureau of Alcohol, Tobacco and Firearms, to the Food and Drug Administration within the Department of Health and Human Services. Would you transfer all regulatory authority over alcohol beverage products to FDA, or only certain activities? How would you do this?

Dr. KILBOURNE. Well, I would think so. I think that, first of all, not very much has been done, given where it has been for so long, and also that it is important to recognize this as a drug and as something that does need to be regulated.

Chairman GLENN. Would you have to split this up? Would some of these authorities be given to FDA and some remain with BATF or other agencies like FTC or the Federal Communications Commission? Do you have any thoughts on that?

Dr. KILBOURNE. If those agencies were really empowered, were really able to do something, but what we have seen in the recent years has been tremendous dis-empowering of these agencies, or a reluctance on their part really to do anything about these issues. So I think that whatever happens, we need to address this issue as a major public health problem and take steps to solve it.

Chairman GLENN. Mr. Burcham, you have heard the comments of our witnesses today, some of whom recommended that prevention, educational initiatives could be greatly enhanced by measures that include increasing the excise on alcohol beverage products, certain restrictions on advertising, the inclusion of health warning messages on alcohol beverage containers. Has the LBIC taken a position on any of these proposals, and could you share those with us this morning and the reasons for their positions?

Mr. BURCHAM. No, we have not, Mr. Chairman. We are not an advocacy group of any kind. Our charter is public education and we decided we wanted to be independent and objective in our efforts. We run our meetings that way and we conduct our programs that way and we do not think it is at all appropriate for us to take stands on issues, controversial or otherwise, in that regard, because it would jeopardize our objectivity or our credibility as a public education organization.

So we do not take stands on any of those issues. I might just add—the only thing I would add, of course, on any of these issues is that we would urge the Committee, as I think you are doing, to investigate as wide and as broad and as deep as you possibly can on all these issues and every aspect of it as you try to come up with solutions to these problems.

Chairman GLENN. Well, okay. But I would think your organization would almost have to take a position on some of these things because it is your product that is causing some 10 million alcoholics and 8 million other problem drinkers across the country and it seems to me that it is not realistic to not take a position on some of these things.

Maybe you are not formed to do that, but if you are not, who is?

Mr. **Burcham**. Well, you are correct, sir, we are not formed to do that and we think that if we did do that, that immediately that would affect our credibility if we were trying to conduct objective programs.

Chairman **Glenn**. Who speaks for the industry in these areas where we have a host of legislative proposals, and there are going to be more, because now that we see some of the concern about smoking going down, you can bet that the next big one where we see some 10 million alcoholics—and I do not think your organization disputes the figures on this—and some 8 million problem drinkers and it is going up and it is advertising that expands that market and so on, and yet we are saddled with doing nothing at this time.

You know, we kill every 3 years in this country, to alcohol-related deaths on the highway kill about the same number of people about every 2½ years as were killed in the whole Vietnam war and the whole Korean war; not together, but in each of those wars we lost 53,000 in Korea, about 58,000 in Vietnam. And about every 2½ years we run through that same total just from alcohol-related deaths on the highways.

How are we going to stop this? It is the product that we are talking about here that causes that and we want to do something about it. I think there is going to be a growing awareness among the American people that is going to result in a demand for some sort of action.

It would seem to me that we either can work together and take some effective measures that are going to address this or you are going to have an awful lot of legislation that is going to come down all over you like a great big tent one of these days.

You know, I would rather be including the industry as part of this solution instead of seeing legislative solutions mandated from on high without your recommendations as to where you want to go with it. So I am looking for guidance here from the industry. We are not starting out on a crusade here to man the fire axes and let's go burn all the bars and start a "Carry Nation-type" campaign here. But on the other hand, you cannot just erase the fact that we kill 50,000-plus people every couple of years through the use of alcohol.

If it was anything else except that we would have such a national outcry you could not believe it.

Mr. **Burcham**. Well, Senator, all I can say is that I have been in the industry for a number of years now and I have a background in other areas and as a member of this council I can certainly say that the people I work with in that council have exactly the same kinds of concerns that you do and that is exactly why we formed the Licensed Beverage Information Council, because in 1980 the Department of the Treasury and then the Department of Health, Education and Welfare, now Health and Human Services, said that they felt education was the best approach to solving these problems. And we have been working very aggressively to try to build a number of programs in the areas related to abuse of alcohol, not only to drinking and pregnancy, but also drunk driving, teenage drinking and alcoholism as a treatable illness.

So again, I just have to say that I know all the members of our council have exactly the same concerns, but we think that we have a very objective role to play here and we do not want to destroy our credibility by appearing to take sides as a council, but what individual groups or companies in the industry do, I do not represent them and cannot speak for them.

Chairman **Glenn**. What is your budget plan for the educational programs in the future? Are your budget plans going up?

Mr. **Burcham**. Yes, sir, I think they are. We do not have—for instance, I could mention again, this season we hope to—especially over the holiday season—to have the "Friends Do Not Let Friends Drive Drunk" campaign very visible again on billboards and on radio and television. We are conducting programs in all of those four areas that I just mentioned and I certainly expect that we will continue to do that.

Chairman **Glenn**. Okay. But the basic problem is we have some problem drinkers that get out of control and cause a lot of the problem here and yet we find the advertising still very enticing, and you mentioned the holidays, and I am sure we will see the Budweiser Clydesdales out there. You have to see that ad. It is a great ad, very appealing. It really is home, hearth, the big old horses coming down there. I have seen them. They are very attractive. And so we have that that increases consumption and holiday deaths will go up, and I do not know how much of it will be due to those horses. Probably we won't blame any of it on the horses. But it makes it very attractive to drink in one area and then at the same time that causes deaths right outside on the highway when you go outside and drive home.

And the magnitude of the amount of money being spent in the prevention or the education about how dangerous it is is not even a pittance compared to the problem that is out there on the highways, just to take one example.

Mr. **Burcham**. Well, I would just say, Senator, that we are trying through our educational efforts to encourage responsible drinking and to remind the public of the possible risks of misuse of the products. That is a big part of the programs that we undertake.

Chairman **Glenn**. Does your industry plan to put up ads on their own now? Or just to call for additional public service time to be given on the stations?

Mr. **Burcham**. The Council program? You are talking about one that I just mentioned, the holiday season?

Chairman **Glenn**. Yes.

Mr. **Burcham**. We would be working, again, with the Outdoor Advertising Association of America and the National Association of Broadcasters and the more time and space that we can get for those messages, the better.

Chairman **Glenn**. Would you favor or oppose a requirement that the same amount of time should be given to the opponent or to the people that are concerned about alcoholism in the country, that they should have the same amount of time that you have on advertising?

Mr. **Burcham**. Well, again, I do not represent those who advertise. I represent a council that provides educational programs and we hope that those are credible programs. They are not trying to get people to drink abusively. On the contrary, they are trying to stop people from drinking abusively and to drink responsibly.

Chairman **Glenn**. Are you doing any advertising or any encouragement to get people who have an alcohol problem just to stop drinking period?

Mr. **Burcham**. Many of our programs use third-party groups, people who are experts in the field. We do not come to conclusions on these issues because we are laymen and many of the people involved in those programs do just that. Certainly for a number of people abstinence is the answer and we promote that in cases where that should be the answer for that person.

Chairman **Glenn**. Some of the comments earlier about the pregnancy problems with drinking and so on, the material that LBIC has produced on alcohol consumption during pregnancy seem to suggest that there may be a safe level of consumption of alcohol during pregnancy. Is that your position on it?

Mr. **Burcham**. Absolutely not. We take no position on what is safe. Again, we leave that to the professionals in the field. We advocate that women of child-bearing age or a woman who is pregnant, that she should consult her physician about her total health program during pregnancy.

Chairman **Glenn**. The medical advice being given to women to abstain from alcoholic beverages completely during pregnancy, you do not take exception to that then? You would say that is okay?

Mr. **Burcham**. We do not take exception, no, sir. We have no stand. Again, we leave that to the experts.

Chairman **Glenn**. I know some of your people—I do not know whether your Council—whether LBIC takes this position specifically—but some of the people have said that advertising only serves to switch from one brand to another.

I have always thought that stretched things considerably. This $1.3 billion to $2 billion a year that we keep hearing about that is the advertising budget for the industry, is that all—then the major part of that is just to switch from one brand to another and not to increase consumption?

Mr. **Burcham**. Sir, I am certainly not a marketing expert and that is out of the purview of the LBIC and we do no advertising other than the educational programs, so, again, I could not speak for those who make the advertising decisions.

Chairman **Glenn**. Well, from your knowledge of this, who does speak for the industry then in these areas and who does speak for the industry on what the industry favors or does not favor in new advertising, new restrictions on warning labels, tougher drunk driving laws, whether we pass laws within the states requiring more visits or putting symbols on automobiles, or all of these things that we were talking about earlier?

Who speaks for the industry and what their view on these things would be?

Mr. **Burcham**. Well, I do not know that there is any one industry position on any one issue. There are a number of associations that are connected with the industry. There are a number of companies in the industry and all I could suggest is that some of them have individual positions on individual issues.

Chairman GLENN. Okay. Thank you. Does anyone else have any closing remarks they wish to make or questions of each other here? Anybody on the panel?

Dr. HINGSON. Senator, I have one comment that was a follow-up to a discussion that you were having with Dr. Grant around the drinking age increases and teenagers obtaining alcohol from their homes.

The work that we have done indicates that when the drinking ages are raised there is a decline in teenage purchasing of alcohol in bars and liquor stores and so on, but simultaneously there is an increase in having someone else, generally just above the legal drinking age, purchasing for the teenager.

Only a small minority of the alcohol that underage teenagers get comes from their own homes or from the homes of their friends and their parents. Most of it comes from someone just above the drinking age thinking that they are doing that teenager a favor by purchasing for them, and I think that we should focus attention on social host liability legislation and see whether or not that may have some impact in deterring people from purchasing and giving alcohol to minors.

Chairman GLENN. Well, we do have some things that look a little promising here. The French experience is one that is surprising, I think, when you look at that, with their background, their history, their culture and heritage and so on. And it has worked over there. I do not know how we put the same thing in in this country. We may have some different reasons why we cannot do the same thing here, but I do not know what they are as far as I am concerned.

We have had specific programs like you talked about of cutting back on drunk driving, the specific groups, teenage groups, where if you have had teenagers around the house recently—which I haven't for a number of years—but I know when you hit that age and your insurance premiums just go up and reflect exactly what was going on with teen drivers, and that is part—part of that problem is the alcohol problem, of course.

This is a problem that is not just a teen problem, though. It is across the board, as I have said repeatedly. We have an estimated 10 million alcoholics and another 8 million problem drinkers and while I certainly favor all the things we are doing with regard for the hard drug problem, the illegal drug problems, we are sort of ignoring this one that is so much larger and so much all inclusive of our whole population.

We have about 4,700 hard drug deaths per year—somewhere approximately in that ballpark—and yet just on the highways we bring body bags in every year of somewhere between 18,000 and 25,000. It goes up and down a little bit every year but alcohol-related deaths alone, 40,000 to 55,000 deaths on the highway each year. It varies up and down a little bit there.

And this evening, when you drive home you will face people coming at you, as I said earlier, that are under the influence of alcohol. It makes you think twice. I may be running into cars over on the right side of the road trying to get away from people. You have to drive defensively when you know that. And on weekend evenings, Saturday evening 20 percent—they estimate as high as 20 percent of the people will have alcohol in their systems at that time on Saturday. That is a frightening figure. It is terrible.

So part of it has got to come as an awareness, I think, as we all work together on that, as has happened in the cigarette situation. But we sure have to get going. I know that the hard drugs are far more addictive early on, first, second, third use some people are hooked, where that isn't quite the case with alcohol. But we did not even get into that this morning, what your opinions are as to the genetic approach to alcoholism as opposed to the habit, just the habit that is formed as opposed to genetic predisposition to having problems with alcohol, and so that goes back then into advertising and treatment and a whole bunch of things when you get into that discussion.

But we need all the advice and counsel we can get and I, frankly, do not know at this point what kind of Federal laws we need beyond just the labeling. I think that is a tiny little first step and I have been surprised the industry doesn't embrace that one and get on with it because why be led kicking and screaming into that one as though that is a big deal, because I do not think it really is.

A person goes into a bar and orders a beer, do they look to see what is in that thing? It is the last thing they look at. All they want to do is see whether it is Millers, Bud, or Lite or whatever it was that they ordered. It is not a big deal so whether you have a warning label on there or not, I think it satisfies some of our psyches that we have done something, but it is a minimal, minimal step as far as I am concerned.

We need a whole lot more than that, so I am surprised the industry hasn't embraced that and cooperated on that one. They look like they are being dragged kicking and screaming into it as though it is some big deal. I do not look at it as being that important at all because we need to do so much more than that with regard to penalizing those who abuse alcohol, drive drunk, wreck lives.

We spend so much money taking care of babies that are born with whatever the problem is, and alcohol contributes to that, so it just seems to me that the warning label is such a minimal, minimal first step that I am surprised anybody even objects to that. But I suppose if the industry makes a big thing out of even something little like that, maybe legislators will be led into thinking they should not dare take on more effective legislation because of the furor that was raised over warning labels, perhaps.

That is not exactly a closing statement. I was just sort of musing thoughts, I guess, or something like that here, but we have to do so much more because there are so many more lives being ruined in this area of alcohol abuse and overuse of alcohol. And then we are even contemplating years down the road with the hard drug problems, the illicit drugs.

So I think we need to work together with the industry, with us, with TV, with advertising, with awareness programs in the schools. All this big thing of high school graduations every spring, we now have quite popular across Ohio and many other States all this thing of a different kind of party, a lot of awareness programs in the schools, and so I think that has been responsible for cutting down a lot of the deaths and difficulties that have occurred.

We have had some success with that across Ohio and other places. I think it is that. It is a whole host of things that we have to do in addition to just the adult treatment and prevention and we need all the best thinking we can get on this.

So we welcome your testimony this morning. We want to all work together on this and any thoughts you have, send them to us. We are going to have this as a continuing series of hearings. We have one more this year. We will be having more next year on this. We want to help in our own little way here with this Committee of raising the awareness of what the problem is. At least that is a first step we can do, too, and then we will see what legislation may come out of this.

So thank you all for being here this morning. The hearing will stand in recess subject to the call of the Chair.

[Whereupon, at 12:45 p.m., the hearing was recessed subject to the call of the Chair.]

APPENDIX

U.S. Senate Governmental Affairs Committee Hearing
June 16, 1988
Joan K. Jackson, Ph.D.

My name is Joan Jackson. I am a trustee of Alcoholics Anonymous, one of a minority of trustees who are themselves not alcoholics. I am a sociologist by training; my doctorate was from the University of Washington in Seattle. Occupationally I have done research on alcoholism, particularly on alcoholism and the family, and have taught medical students and the candidates for other professional degrees about alcoholism. I have also participated in the setting up of state and local alcoholism programs.

In order to address your inquiry about "The Alcoholics Anonymous philosophy of alcohol abuse treatment" I would like to begin with a statement which has been read at every A.A. meeting for many years.

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recovery from alcoholism.

The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership. We are self-supporting through our own contributions.

A.A. is not allied with any sect, denomination, politics, organization or institution, does not wish to engage in any controversy, neither endorses nor opposes any causes.

Our primary purpose is to stay sober and help others to achieve sobriety.

That is, of course, a very compressed statement of what A.A. is. Let me elaborate on the beliefs and principles of Alcoholics Anonymous as I see them.

1. Alcoholics Anonymous is what is popularly termed a "self-help" society. That is, people who have a common problem recover by helping each other to follow a program of recovery which they have evolved.

2. From the beginning A.A. members have regarded alcoholism as an illness. Alcoholics cannot control their drinking because they are ill in their bodies and in their minds (or emotions). Most A.A.s believe that spiritual deficiencies also characterize their illness.

3. Alcoholics Anonymous believes that effective recovery can only begin with a "self-diagnosis"; that is, with a

recognition by the alcoholic that he cannot control his drinking or its intolerable consequences.

4. A.A. also believes that recovery involves abstinence from alcohol, and that abstinence on a long-term basis requires fundamental changes in his relationships with himself, with others, and with some power greater than himself. That is because it is the conviction of Alcoholics Anonymous than an alcoholic can never safely drink again.

5. A.A. believes that once an alcoholic, always an alcoholic, i.e., that no matter how long a person is abstinent, if he drinks again he will have the same disastrous response to alcohol that characterized his pre-abstinence drinking. Thus A.A. does not offer cures, but, rather, a continuing process of recovering.

6. Researchers, physicians and others concerned with alcoholism have a legitimate and natural concern with identifying the causes of alcoholism. But for the program of Alcoholics Anonymous causes are not only considered irrelevant but also as possibly distracting from undertaking the straightforward abstinence and recovery program.

7. Recovering in A.A. is an ongoing process of personal change guided by what are called the Twelve Steps of Alcoholics Anonymous. These are:

> 1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
>
> 2. Came to believe that a Power greater than ourselves could restore us to sanity.
>
> 3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
>
> 4. Made a searching and fearless moral inventory of ourselves.
>
> 5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
>
> 6. Were entirely ready to have God remove all these defects of character.
>
> 7. Humbly asked Him to remove our shortcomings.
>
> 8. Made a list of all persons we had harmed, and became willing to make amends to them all.
>
> 9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

In other words what is involved is an acceptance by the individual of an alcoholism problem and its associated problems in living and a recognition of his own inability to change these through his own efforts; a willingness to follow the example of people who, he is convinced, had the same problems and who are now abstinent and obviously solving their problems; and a willingness to appeal for help to sources of power outside himself, whether he defines this power as his A.A. group, a vague spiritual entity or as God.

8. This process of recovering goes on in A.A. groups, - small numbers of recovering alcoholics, who engage in one-to-one sharing about their alcoholism. their experiences, and their solutions to problems. The only requirement for membership in a group is a desire to stop drinking. In these small groups the newcomer learns to recognize his illness and the interaction between the illness and his problems through identification with others who have obviously been like himself, a process which occurs only with great difficulty in other contexts. He also sees concrete evidence of the effectiveness of the A.A. program in the obvious present well-being of the members of the group who provide him with a variety of patterns of "working the program." As he engages in efforts to change himself, group members provide continual and, if needed, intensive support.

9. The Alcoholics Anonymous program and philosophy are described in various A.A. publications, samples of which I have sent to this committee. The fundamental text-book is the book, Alcoholics Anonymous.

The Place of the Traditions in A.A. Organization and Program

1. There are more than 43,000 A.A. groups in the United States and Canada and more than 73,000 world-wide. They are loosely linked together by the practice of this common recovery program, and by a set of twelve Traditions which guide their relationships with each other and with society as a whole. Only a few will be mentioned here.

2. These groups, and the Fellowship as a whole, are entirely supported by their own voluntary contributions. No money is accepted from outside sources, and only limited amounts from any single person within A.A.

3. The Fellowship restricts itself to the recovery from alcoholism of its members and potential members, i.e. alcoholics who are still drinking. Although it cooperates with any others who are concerned with helping alcoholics to recover, it is not formally allied to any such organization. Furthermore, it has no opinions on other treatment modalities or related matters.

4. The Fellowship regards its traditions as crucial to the maintenance of its uniquely effective, narrowly focussed program of recovery from alcoholism. And the most crucial of all the traditions is that personal anonymity be maintained at the public level, as implied by the name Alcoholics Anonymous. This anonymity symbolizes the importance of the group over the individual, and of principles over personalities. It also symbolizes the sacrifice of personal gain and individual ego satisfaction required to begin and carry out an effective recovery.

5. A.A emphasizes the attraction of new members through the examples it provides of successful recovery, rather than through advertising or promotional activities.

The Demographics of Alcoholics Anonymous Members

1. The membership of A.A., past and present, is very imperfectly known. It is part of the nature of the Fellowship that specific data on individuals is not required. However, members currently active in the United States and Canada number about 800,000, although it is my educated guess that at least this many more have achieved sobriety in the past and are no longer active.

2. The world-wide membership is perhaps double that of United States and Canada, and is distributed in about 100 countries.

3. In North America the membership is heaviest around the major cities of both coasts and of the midwest. The details of the distribution are shown on the map I have included with the materials sent to this committee.

4. Certain characteristics of the membership are known to us in terms of overall averages. In the materials sent to this committee is the pamphlet AA Membership Survey which we issue every three years, and which summarizes the only comprehensive surveys we do. It shows that about one-third

of our membership is women; about 20% are thirty years old or less.

5. We do not gather information on membership in religious or ethnic groups. We do know, however, that there are many A.A. groups among various ethnic populations, and A.A. literature in many languages is distributed in this country as well as through the world.

Utilization of the A.A. Approach to Treatment in Other Alcohol Abuse Treatment Settings

1. While we cooperate widely with treatment programs and with professionals who treat alcoholism, primarily by making A.A. available as a resource for the long-term maintenance of sobriety, the details are more appropriately presented by those who use us in that way. We are aware that our twelve-step program of recovery has been incorporated into the programs of many treatment facilities and that large numbers of our members assist treatment facilities in many ways.

2. Because of this wide-spread relationship, A.A. has hundreds of local Treatment Facilities Committees whose purpose is to make our resources available in the most effective way.

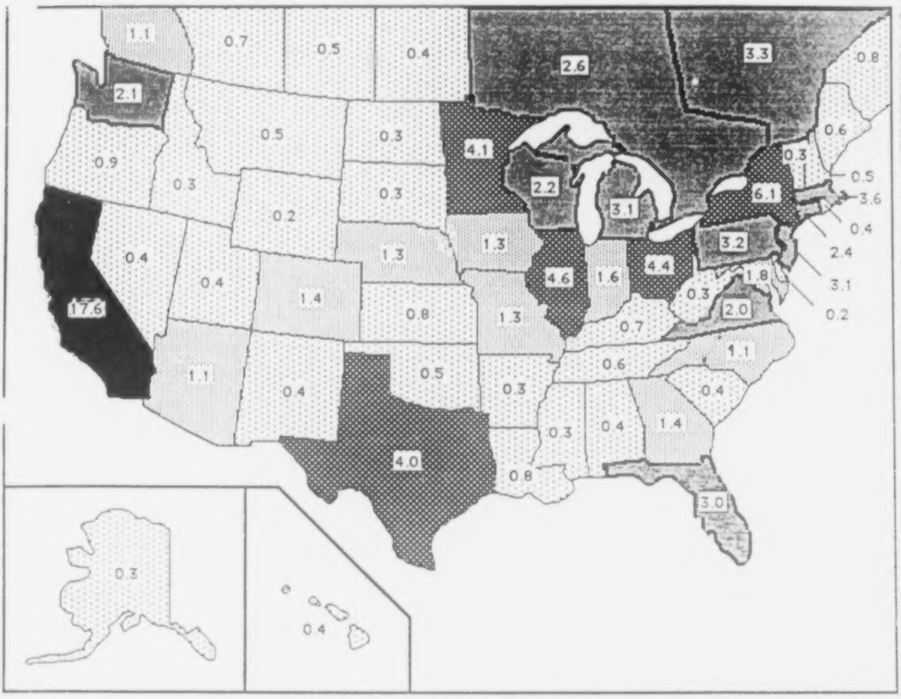
3. While we know that our resources and our program are used in various ways by hospitals and other treatment institutions, we do not regard it as within our traditions to monitor or to prescribe the manner of their use.

Effectivenes of the A.A. Approach

1. A.A. does not believe that it is possible for an alcoholic to return to "non-problem" drinking.

2. With respect to the numbers of alcoholics who have remained sober through the A.A. program, we have no hard statistics. The extent and continuing rapidity of our growth suggests that large numbers achieve lengthy periods of sobriety. Our membership survey indicates that roughly a third have been sober less than one year, a third sober between 1 and 5 years and a third over 5 years. We have no information on how many of those who are no longer active in A.A. have maintained sobriety. For more rigorously derived information, we must refer you to those who do research on alcoholism and to the follow-up studies of the treatment institutions who use our resources.

DISTRIBUTION OF 1987 AA MEMBERSHIP
BY PERCENT OF TOTAL
CANADA AND USA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Legend:

- ░ Less than 1%
- ░ 1% to 1.9%
- ▒ 2% to 3.9%
- ▓ 4% to 6.9%
- █ More than 6.9%

July 19, 1988

ALCOHOLICS ANONYMOUS
REPLY TO ADDITIONAL QUESTIONS OF JUNE 23, 1988
SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS

1. Is it your position that Alcoholics Anonymous is an appropriate and effective primary treatment program for all problem drinkers or only for alcoholics?

Alcoholics Anonymous offers a program of recovery to all persons who have experienced problems with drinking of a nature and to the extent that they define themselves as alcoholics, i.e., as unable to manage their drinking and their lives without help. AA does not differentiate between problem drinkers and alcoholics. It views alcoholism as a progressive condition involving the loss of control over drinking, and the loss of control is defined by the individual himself. It is unlikely that a heavy drinker who could control his drinking would be interested in membership in AA. Our experience suggests that, for alcoholics, it is an appropriate and effective primary treatment program.

2. Has Alcoholics Anonymous conducted any studies on why people drop out of the AA program? Have you conducted any studies on the characteristics of people who seem to improve in AA? How do these people compare with persons who drop out of, or do not improve with, the AA program?

We have not conducted such studies. It should be noted that it is not uncommon in AA, and, I understand in other treatment programs, for alcoholics to come to treatment several times before lasting abstinence is achieved. AA does not define dropping out of AA as "failure to improve" or as "failure", particularly in the first few months, but, rather, as a sign of not being ready yet.

3. How important are patient factors in predicting a favorable outcome in AA? What are the patient characteristics that have been associated with continued sobriety in AA?

It has been our experience that recovery involves permanent abstinence from alcohol, and that abstinence on a long-term basis requires fundamental changes in the alcoholic's relationship with himself, with others. It involves accepting his inability to handle his life without help. Recovery is an on-going process which occurs in the context of the AA program and AA group. Thus long-term sobriety tends to be associated with being active in AA groups and activities. We recognize that the "patient characteristics" which we focus on are not those usually studied.

4. How has the AA program and treatment philosophy responded to the changing pattern of alcohol dependency -- from exclusive dependence upon alcohol to poly-substance abuse?

Alcoholics Anonymous' primary concern is with alcoholics and their alcoholism. Increasing numbers of those who come to AA are also users of drugs other than alcohol, 38% in our 1986 survey. The most usual adaptation to this situation is for AA groups to request that only alcohol problems be dealt with in AA and problems related to other drugs be dealt with in the appropriate other twelve step program, e.g. Narcotics Anonymous, Cocaine Anonymous, etc. (It is our understanding the other twelve step programs handle the alcoholism of their members in the same way.) AA members, as individuals, often help these other-drug addicted newcomers to make contact with the other program.

5. Is it your position that AA is best used as an exclusive treatment strategy for alcoholism or as an adjunct to other treatment components?

We do not take a position on this question. However, some observations are relevant. Some of our members came to AA and immediately began the path to recovery and have never used any other treatment. Others came to AA, dropped out, came again and began to recover. For some it was the only treatment program embarked upon, while some tried other kinds of treatment before returning to AA. Others of our members had many different kinds of treatment before beginning to recover in AA, and still others have combined other kinds of treatment with AA. 36% of our members in 1986 came to AA through rehabs and/or counseling, up from 19% in 1977. This is most important for members under 30 years of age.

6. What is your position on the use of AA within the context of a multimodal treatment program?

AA is - and has always been - willing to respond positively to requests by treatment programs for its cooperation. AA has active Treatment Facilities Committees at each level in its structure (i.e., at the level of the Board of Trustees of the General Service Board of AA, through regional, district and local structures) and in every geographic area of the United States and Canada. These committees are actively engaged in cooperating with treatment programs, - programs which have a wide range of orientations. AA does not have opinions on the various treatment orientations. Rather, our concerns are to work effectively with treatment institutions which request our cooperation, whatever their orientation. (Insofar as your question may encompass treatment programs which also involve the courts or penal institutions, I should mention that there are also active Correctional Facilities Committees which respond to requests for cooperation from the legal system.)

Having served as Chairman of the Trustees Treatment Facilities Committee on two occasions within the last 5 years, it is my observation that it is a very rare treatment facility which has not requested the cooperation of AA members in some aspect of its program. Treatment programs could provide you with information about the variety of ways in which AA cooperates.

7. Is there an accepted model for alcoholism treatment that has proven to be effective for all persons with an alcohol dependency? If so, would you describe for the Committee what this treatment model is?

As stated above, Alcoholics Anonymous does not have an opinion on other forms of treatment for alcoholism or about their effectiveness. AA believes that its own program of recovery can be effective for most, but not all, alcoholics. The program requires a rigorous self-examination and a level of motivation that some alcoholics do not seem to be able to manage.

8. Is one particular treatment model or method applicable to all populations? Do we have to develop specific approaches to treat different populations of problem drinkers?

The answer to this question is the same as for question 7 above. It should be noted, however, that although there is a single program of recovery offered by AA, there are an infinite number of ways in which this program can be implemented. AA members are very sensitive to the characteristics of newcomers and tend to give very individualized attention to each one. In this limited sense AA has recognized that not all alcoholics can be treated exactly the same.

9. In a review of the controlled trial literature on Alcoholics Anonymous, Dr. Miller has concluded that none of these studies found a beneficial treatment effect from AA, using sobriety/abstinence as the outcome being measured. What has been your experience with the success of AA in maintaining life-long abstinence in AA members?

AA would not consider it to be appropriate for it to comment on the studies cited by Dr. Miller.

With respect to the second part of this question, there are few AA members who do not know many fellow members who maintained sobriety up to the time of their death. Such maintenance of sobriety is not at all uncommon. However, as AA does not keep track of the success of its members in these terms, perhaps the figures our surveys have provided on length of sobriety among AA members still actively attending meetings can be helpful.

The General Service Office of Alcoholics Anonymous has surveyed AA membership in the United States and Canada on a triennial basis since 1968, to determine the characteristics of the membership and trends in those characteristics that are of interest to the membership, the professional community and the public. A pamphlet, "AA Membership Survey" was included with the material submitted to this committee in June. Average length of sobriety of AA members who actively attend meetings was 52 months. 29% were sober over 5 years, 38% sober between 1 and 5 years, and 33% had been sober less than one year. The figures on those sober more than a year had been remarkably constant for the first six surveys, varying between 59% and 63%. In the 1986 survey, this figure rose to 67%, which was a statistically significant difference. The figures on sobriety have also been analyzed to show the probability of maintaining sobriety for a year beyond the year surveyed. The results of this analysis, also very stable since at least 1977, are: "1) A randomly selected member of the population with less than a year's sobriety has an approximate 40% chance of remaining sober another year. 2) A randomly selected member with 1 to 4 years sobriety has an approximate 80% chance of remaining sober and active in the Fellowship another year. 3) A randomly selected member with more than 5 years' sobriety has an approximate 90% chance of remaining sober and active another year." The survey did not include long-term members of AA who are no longer active and attend meetings. We cannot state with any precision how many of these are maintaining abstinence. However, there is reason to believe the larger proportion of those who were sober 5 years or more at the time they ceased attending meetings are still sober.

10. A witness to one of our earlier alcoholism hearings recommended that NIAAA allocate increased funding for data collection, prevention and psychosocial research, and the establishment of a national research center on Women, Alcohol, and other Drugs. How do you feel about this suggestion?

11. It has been suggested that the Federal Government maintain a mandatory data base on clients that use publicly funded alcohol abuse treatment services. Do you feel that such data collection activities ought to be re-established as a formal, Federal mandate or should the data collection activities remain as they are?

AA would not have an opinion on either of these questions. However, with respect to question 10, it is my opinion and experience that whatever kind of research is decided upon, researchers will find large numbers of individuals in AA who would cooperate with their research undertakings.

The Hazelden Treatment Model

Prepared for The Senate Committee on Governmental Affairs

June 16, 1988

I. The Hazelden Treatment Model

II. How Managed Care Threatens the Continuum of Care

III. Personal, Social, and Economic Benefits of Treatment

For clarification or further information, contact Damian McElrath, Director of Residential Services, Hazelden Foundation, Box 11, Center City, Minnesota, 55012, (612) 257-4010.

The Hazelden Treatment Model

The Hazelden treatment model, also known as the Minnesota Model, is the most successful and prevalent form of treatment available.

The form of chemical dependency treatment practiced at Hazelden and replicated by treatment programs throughout the US evolved in the 1950s and '60s and has been continually refined since that time.

It is the most successful form of treatment for chemical dependency in recorded history. Between 50 to 75% of patients treated using this model are still abstinent from alcohol and other drugs one year after treatment.

The philosophy that underlies this treatment practice is based on these assumptions:

Alcoholism exists. At the time this model of treatment was developed, alcoholism was largely ignored, or at best seen as a problem limited to a few skid row bums. It was unthinkable that any person of better means would be an "alcoholic."

Today, alcoholism is accepted in most parts of the country. But it is important to remember that this "skid row" attitude still colors the way many people think about alcoholism.

Alcoholism is an illness. Alcoholics have both a pathological dependence on alcohol and an impaired ability to control their consumption of the drug. Significant research exists substantiating a hereditary factor in at least some forms of alcoholism.

Our treatment approach is based on the observation that chemical dependency is an involuntary, chronic illness, like cancer or heart disease.

Alcoholism is a not the victim's fault. If one takes the position that alcoholism is an illness, like cancer, heart disease, or diabetes, one cannot hold the alcoholic personally responsible for the disease itself. This does not mean that the alcoholic is not responsible for actions taken while drinking, such as drunk driving. But it does recognize the involuntary nature of the condition; alcoholism is not a bad habit, but an involuntary loss of control.

Alcoholism is multiphasic. It affects every area of the afflicted person's life: physical condition, psychological function, social behavior, and spiritual well-being.

Alcoholism is a chronic, primary illness. It is not a symptom of some underlying condition. In fact, it can exist alongside of psychiatric disorders as well as physical ailments.

The alcoholic does not have to want treatment in order to benefit from it. Research on patients who were committed to treatment against their will shows that they do as well in treatment as those who voluntarily enter treatment.

A person can be addicted to more than one drug, including alcohol. Treatment programs frequently see people whose addiction includes alcohol, cocaine, and other chemicals. This is why we call the disease chemical dependency.

As a result of these observations and assumptions, the basic treatment model used at Hazelden and followed by many other treatment programs includes:

A multidisciplinary treatment team, together with the patient's peers in treatment, helps the patient prepare for a life free of alcohol and other drugs.

A commitment to **total abstinence** from all potentially mood-altering substances, including alcohol, prescription medications that are mood altering, and illicit drugs.

Indoctrination into the practices of **Alcoholics Anonymous**, the best-known and most effective support group for recovering alcoholics.

The concept of **care vs cure**. Alcoholism and other drug dependencies can never be cured; one cannot learn to use these substances in small, socially acceptable amounts once addiction has developed. Experience has shown that such use will inevitably lead to a complete relapse of the behavior.

Use of a **multidisciplinary treatment team**, including counselors, psychologists, medical staff, clergy, recreation specialists, aftercare specialists, and family counselors, because alcoholism affects all areas of a person's life.

Reliance on other alcoholics to encourage recovery. **Peer group process** is essential to our form of treatment, as patients learn to make change by watching and talking to one another.

Education about alcoholism. To maintain lifelong sobriety, alcoholics need to learn about their disease, just as the diabetic needs to learn new diet patterns. This education occurs through lectures, videocassettes, small groups, and homework assignments.

Individual treatment plans for each patient. While the "big picture" for the progression and arrest of chemical dependency is the same, every person is different. Family, social resources, hometown, length of addiction, types of drugs used, existence of complicating psychiatric disorders, and many other factors necessitate a separate course of treatment for each person.

Aftercare counseling and relapse prevention to help each patient enjoy a full, healthy sobriety and avoid the risk of relapse of the illness.

How managed care threatens the continuum of care

The continuum of care for chemical dependency evolved as a practical and cost-effective response to the different levels of care required by different patients. The current practices of managed care often usurp this humane, beneficial approach.

In the past 40 years, the Minnesota model has developed a continuum of care for chemical dependency that includes prevention of alcoholism, early intervention, long-term treatment for the chronic relapser, and the promotion of high-level recovery for chemically dependent people and their families.

The continuum of care evolved as a practical response to the observation that all clients bring different situations to treatment. Some, who have strong social support networks and a less severe history of chemical dependency, may need only outpatient treatment. Others may need residential care, extended treatment over several months, halfway houses, and various forms of aftercare counseling. Families, too, vary in their needs for education and support.

This network makes it possible to assess each patient and match her or him to the appropriate type and level of care. Individual circumstances that affect the level of care needed by the patient include:

-the degree and type of problem

-the problem's longevity

-the number of associated problems

-external support from family and friends

-the person's motivation to change

-the person's ability to understand treatment

The continuum of care evolved long before the financial crisis hit our nation's health care system earlier this decade. The continuum of care is (and was) a cost-effective response to matching services to level of need. Outpatient programs developed because some patients needed only that level of care, not as a way of cutting cost.

Unfortunately, in today's health care environment, managed care often means finding the cheapest and quickest form of care, not the most cost-effective form or the form that best fits the patient's needs. Under many managed care plans, including health maintenance organizations, patients have very limited access to the continuum of care.

Such organizations often refer patients only to outpatient programs, referring to residential care or longer-term treatment only after repeated failures with more limited forms of treatment--and after considerable suffering on the part of the patient and family.

Clearly, the direction is simply short-term cost savings, with no attention to the patient's true needs. Would we force a cancer-stricken person to first try some low-cost but ineffective treatment when in fact, an operation would alleviate the problem completely?

Alcoholism is a disease. Patients need to receive the level of care that fits their individual situations. Good diagnosticians assess a chemically dependent person's needs, refer to the most appropriate level of care, and, in the long-run, assure that the patient will begin recovery and avoid relapse with the least amount of pain--and cost--possible.

Personal, Social, and Economic Benefits of Treatment

Treatment for chemical dependency has substantial personal, social, and economic benefits.

While abstinence is the primary goal of treatment, patients also experience improved quality of life, relationships, employment, and health, and decreased legal problems. This results in social and economic benefits for the patient, employer, and society as a whole.

Most patients are employed full time. The average length of stay is 29 days. One year after treatment, almost 70% were completely abstinent.

The following statistics, drawn from research on patients 12 months after discharge from treatment, will demonstrate these assertions. First, some information about our patients, based on a survey of patients in treatment during 1985. Two-thirds of these patients were male. Close to half were married; 29% were single, 23% were separated or divorced, and 2% were widowed. Most (81%) were employed full-time; 13% were unemployed, and the remainder were students or retired. The largest block of patients were 26-35 years of age (36%), while 8% were younger than 26, 27% were 36-45, 18% were 46-55, and 11% were older than 55. In 1985, patients stayed at Hazelden from 1 day to 58 days, with the average length of stay 29 days.

One year after treatment, 68% had never used alcohol and 11% had tried alcohol only one time. Eighty-seven percent had never used drugs or used them only for medical reasons; 5% had tried drugs only once after treatment.

To support their sobriety, most (77%) of these patients attend Alcoholics Anonymous.

The great majority of these patients reported improved relationships in all areas of life.

After treatment, patients report improved relationships with spouse, family, and Higher Power, and much improved personal growth.

Eighty-six percent noted an improved relationship with their Higher Power, including increases in prayer and meditation.

One year after treatment, 75-85% of the respondents felt their relations with spouse, significant others, and immediate family had improved. Sixty-nine percent noted a reduction in problems with family and friends.

These patients also reported a much improved quality of life. In eight indicators of maturation and growth, 83-91% of the respondents noted improvements. These areas included general enjoyment of life, recognition of the need for abstinence, ability to cope with problems, ability to assume responsibility, ability to accomplish tasks, emotional health, physical well-being, and self-image.

Employers benefitted from an employee's treatment, as absenteeism, tardiness, accidents, and hospitalizations dropped after treatment. At the same time, job performance and satisfaction improved.

Recovery also benefitted these patients' job situations and their employers. Respondents reported reductions in absenteeism, use of sick days, tardiness, accidents at work, and use of drugs at work. In the year since leaving treatment, 55% of those surveyed had missed no days of work because of illness; 26% had missed 1 to 3 days, and only 4% had missed more than 10 days.

In terms of job attitude, job performance, and job satisfaction, 80-89% of the respondents noted improvement in those areas. Two-thirds of them noted fewer problems on the job, while 24% had no work-related problems.

For the most part, these patients also used fewer health benefits in the year after treatment. Ninety-four to ninety-eight percent reported decreases, or had never required, hospitalization for chemical use, emergency services, or other reasons.

More than half the people surveyed had not used or had decreased their use of medical doctors, other medical professionals, and counseling services; although 30% had increased their use of counseling services. This increase is probably because some form of counseling was recommended to the patients as part of their aftercare for chemical dependency treatment.

The final area of significant benefit to society, family, and individual, was a change in legal problems. Compared to the year prior to treatment at Hazelden, everyone surveyed indicated that arrests and time spent in jail either decreased (5%) or had never occurred (95%). Legal problems were reduced or nonexistent for the majority of those patients surveyed.

A more complete listing of statistics is available from Hazelden Planning and Evaluation, Box 11, Center City, Minnesota, 55012. Request the Hazelden Primary Rehabilitation 1985 Twelve-Month Outcome Study. Other studies also available.

QUESTIONS FROM SENATOR GLENN AND RESPONSES BY HAZELDON FOUNDATION

1. Is there an accepted model for alcoholism treatment that has proven to be effective for all problem drinkers? If so, would you please describe for the Committee what this treatment model is and the characteristics of the treatment population it is intended for? Is one specific treatment model applicable to all populations?

2. Do we have to develop different approaches to treat specific populations? How important is treatment "matching" in terms of a favorable treatment outcome?

3. How would you define the term "alcoholism"? Is anyone who considers him/herself to have a "drinking problem" an alcoholic?

4. You have stated in your testimony that the Hazelden Treatment Model "is the most successful form of treatment for chemical dependency in recorded history." Has your organization conducted comparative treatment studies that would substantiate this claim? Have these studies been published in the peer-reviewed alcoholism treatment literature?

5. You have also stated that "between 50 to 75% of patients treated using this model are still abstinent from alcohol and other drugs one year after treatment." This would imply that 25 to 50% of patients treated using the Hazelden approach failed to mention abstinence from alcohol and other drugs one year after treatment. Could you explain why some patients succeed - while others fail - in alcohol abuse treatment using the Hazelden approach?

6. How much does the Hazelden Program cost? Is this cost paid by third-party insurance companies, from personal resources, Medicare/Medicaid, or some other form of payment?

7. Your testimony on page 6 of your prepared remarks would seem to suggest that the most intensive, residential treatment is associated with the most favorable treatment outcome in recovering alcoholics. This conclusion appears to be at variance with the statements of Drs. Miller and McLellan that suggest that residential treatment settings yield no higher overall rates of successful outcome than less expensive, non-residential treatment alternatives. Could you explain the basis of your statement about treatment intensity and successful outcome?

8. Dr. Miller has testified that in Europe greater emphasis is given to standards and strategies for drinking within safe limits. Treatment in the U.S. places greater emphasis on total abstinence. Could you explain why self control training is not standard practice in the U.S. as it is in Europe?

9. A witness to one of our earlier alcoholism hearings recommended that NIAAA allocate increased funding for data collection, prevention and psychosocial research, and the establishment of a national research center on Women, Alcohol, and Other Drugs. How do you feel about this suggestion?

10. It has been suggested that the Federal Government maintain a mandatory data base on clients that use publically funded alcohol abuse treatment services. Do you feel that such data collection activities ought to be re-established as a formal, Federal mandate or should the data collection activities remain as they are?

Hazelden

Office of the President

August 4, 1988

Senator John Glenn
United States Senate
Committee on Governmental Affairs
Washington, D.C. 20510-6250

Dear Senator Glenn:

Upon returning from testifying before your Committee, Damian McElrath, Ph.D., indicated you would be interested in hearing additional ideas on how government could be of help to the chemical dependency field.

I hope my response will be brief, but it probably will not be.

First, the government should recognize two fine organizations--NIAAA and NIDA. Considering their resources, they do an outstanding job. Given more resources, I believe they could have a greater impact. This is not to say we always agree with the positions of their leaders.

At the state level, there is a system of single state agencies throughout the country that can and do work very closely with NIAAA and NIDA. That system could be reinforced and accorded additional help.

Access to chemical dependency treatment: An increasingly critical issue. There seems to be fewer public dollars available to fund treatment for those in need. In the private sector, it is clear to me that everyone is trying to reduce healthcare costs. The various efforts to reduce healthcare costs have, indeed, **created barriers to treatment** or at least barriers to individually appropriate treatment, i.e., required pre-admission authorization from an individual's insurance program, prior to entering treatment. Pre-admission authorization is probably no problem for someone with lower back pain or other

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straightforward medical problems. However, for the chemically dependent who does not want treatment, the authorization becomes a major barrier and perhaps treatment is deferred.

Pre-admission authorization is part of **managed healthcare.** Managed healthcare includes various utilization review/length of stay limits. The external reviewers retained by insurance companies and employers are typically untrained and inexperienced in chemical dependency. The result is that many treatment centers are having difficulty collecting payment from insurance companies. The average length of stay for treatment paid by insurance companies is falling. Hazelden has been fairly succcessful in dealing with this element, but it is difficult for many other treatment centers.

I don't know what federal government could/should do about managed healthcare. Healthcare and insurance tends to be regulated on a state basis. Fortunately, we do have many states mandating third-party coverage for chemical dependency treatment. That mandate is clearly endangered by the minimum healthcare coverage for everyone, (SF#) sponsored by your colleagues. That federally mandated minimum healthcare coverage for everyone is a very humane idea, but could, inadvertently, override state mandates for chemical dependency coverage. Historically, our experience has been that without mandates, insurance coverage is not provided for chemical dependency treatment.

These financial forces tend to stereotype the chemically dependent, i.e., outpatient treatment is effective and less expensive, therefore, everyone in need of treatment should go to outpatient. The former is true; outpatient is effective, but for certain people. We are dealing with a complicated disease and, as you would know, all forms of treatment must be available, i.e., short-term, long-term, inpatient, outpatient, etc. The type of treatment is dictated by the needs of the patient. Unfortunately, there is no nationally agreed upon criteria for levels of care. The National Association of Addiction Treatment Providers in Irvine, California, has published a good set of such criteria. Perhaps criteria for levels of care is a project the federal government could help fund.

The federal government has played a major role in helping to destigmatize this disease. I think the federal government should continue, and perhaps increase, its efforts in the area of public education. We need to keep the disease concept as our driving force. The recent Supreme Court decision/non-decision on the disease concept has left lingering doubts in the minds of many, including the media, about the disease concept.

I have previously written to you on whether there is a need for a "drug czar." At best, we are ambivalent about it. The issues are so complex, I wonder if one person could adequately comprehend the need for treatment, education, research, and law enforcement in a balanced manner. In our opinion, the current effort on the part of the federal government is tilted much too far toward law enforcement, e.g., zero tolerance. The problem will never be solved by trying to seal the borders. Synthetic imitation drugs can and are being manufactured within our borders very easily and cheaply.

An alternative to a drug czar, once again, would be the existing structure of NIAAA and NIDA. Even with the informed leadership in those agencies, it is sometimes difficult for them to strike a balance between the biological, psychological, social, and spiritual aspects of this disease.

In a recent letter to Damian McElrath, you requested Hazelden's opinion on additional questions not raised at the hearing. I will try to respond to those questions.

Is there an acceptable model for all alcoholism treatment that is proven effective for ALL problem drinkers? Unfortunately, the answer is no. The most effective program, of course, has been the self-help movement of Alcoholics Anonymous. We believe the next most effective is the multidisciplinary individualized treatment programming, as practiced by Hazelden and others.

This system uses the concepts of Alcoholics Anonymous, combined with the efforts of a multidisciplinary professional staff. The characteristics of this system focus on the utilization of Alcoholics Anonymous with a desired outcome of total abstinence from all mood-altering chemicals and improved quality of life. There are certain chemically dependent populations that are extremely hard to reach with any known treatment method, i.e., "skid row." It is common that those individuals might respond to long-term programs, which generally are not available.

Is one specific treatment model applicable to all populations? Again, we could not say one specific treatment model is applicable to all populations, e.g., some people with organic impairment would require quite a different approach.

Do we have to develop different approaches to treat specific populations? There are a wide variety of treatment approaches already in existence. As indicated above, access to those programs is, in some cases, increasingly difficult.

How important is treatment matching, in terms of favorable outcomes? Treatment matching is a pressing issue in the field. We do not have a good national system for treatment matching. As indicated above, NAATP has developed an initial draft that looks good and would be worthwhile for you to look into (see attached). Treatment matching may, in many cases, improve outcomes. Because of decreasing resources, we should cautiously place patients in the most appropriate, least-costly program.

How would we define the term "alcoholism?" In a very loose way, your suggestion is that anyone who considers himself to have a drinking problem, probably does have a problem and, in all likelihood, is an alcoholic. Our definition of alcoholism or other chemical dependencies is briefly stated as follows: "Drinking/use followed by trouble, followed by more drinking/use, indicates lack of control, thus, the addiction; anyone in full control of their lives, once having had trouble when drinking, would modify their behavior to avoid that trouble in the future, i.e., drinking and driving."

You quote Damian as saying the Hazelden treatment model is the most successful form in recorded history. In one literal sense, it is probably true because of our long history in the field. However, I would say Alcoholics Anonymous probably has had more success, numerically, than has any particular form of treatment. We have conducted comparative treatment studies, which have been published in various places.

Why do some people succeed and others fail in treatment? A good question to which there are many answers and some unknowns. Some of the obvious factors are social and vocational stability. An unemployed young male with no career will not do near as well as an airline pilot. Other issues, such as participation in aftercare, follow through with Alcoholics Anonymous, are fairly good predictors of who will stay sober and who will not.

How much does a Hazelden program cost? The cost of a course of treatment at Hazelden Foundation runs close to $5,000 for a month. (I think you would find that to be on the low end of the price range in the field.) A course of treatment of similar length at other treatment facilities can range in price from $8,000 to $20,000 nationally, at a variance I cannot explain. Treatment for adolescents and young adults at Hazelden is about $6,000 due to the typically longer length of stay. The cost of treatment is paid by third-party companies, some from personal resources. Medicare and Medicaid **does not** reimburse for chemical dependency treatment at freestanding facilities such as ours. Medicare will only reimburse for chemical dependency treatment in acute care facilities, i.e., general hospitals at, ironically, a higher cost.

There are more than one individuals who would agree with Dr. Miller that residential treatment centers yield no higher overall rates of successful outcomes than less expensive, non-residential alternatives. Yes, there are other forms of treatment that are effective, i.e., outpatient. This does not mean they are interchangeable for a given patient population. One explanation for why both would get good treatment outcomes is perhaps the patient population served at each facility is different possibly due to good admission screening by both the outpatient and the residential centers.

You will also find "experts" in the field who will even tell you there is no evidence that treatment is any more effective than non-treatment. Further, there are other experts who will say there is no scientific evidence that treatment works at all. But we do have on hand our own outcome evaluation data and a large number of very sober alumni, as evidence that treatment does work.

Dr. Miller has testified that in Europe greater emphasis is given to standards and strategies for drinking within safe limits vs. U.S. emphasis on total abstinence. This is a complex issue that is not well explained in a brief letter, but still we will try. I believe emphasis on total abstinence in our treatment programs is a reflection of the success of Alcoholics Anonymous. The clinicians may use different language, but an A.A. member would tell you that they have tried self-control time and time again, only to fail. They may further tell you that having one or two drinks, or even three or four drinks, is not worth the effort. It does not bring them the feeling of euphoria that they associate with drinking. We do not attempt to teach controlled drinking in our programs for similar reasons. We are dubious of its outcome and we believe it's hardly worth the effort. The person who abstains from alcohol has really given up very little and will gain a lot in terms of lifestyle and health.

We do believe in preventive work, working with young people, teaching refusal skills, coping with peer pressure, etc.

The issue of European drinking, I believe, cannot be generalized. True, in some European countries, there are fairly strong societal limits on drinking. Italy is an example, where the per capita consumption is comparatively high. At the same time, rates of alcoholism are comparatively low. But there are strong cultural norms about intoxication. We lack consistent attitudes toward intoxication in this country. In Great Britain, there is a strong emphasis placed on controlled drinking. I think this arises out of the high value that culture places on having a couple of sherries a day, if you will. At the same time, Great Britain has its fair share of alcoholism. If you travel in England, you will find clinicians who will admit that their traditional approaches to alcohol and drug treatment are generally not known for their effectiveness. Further, there is a very strong interest in Europe in our type of program. In Sweden, they will quite frankly tell you that their traditional methods of treating alcoholism are a dismal failure. They find our model, the total abstinence, and the spiritual aspects of our program to be very exciting. The end result is that there are numerous imitations of our type of program growing up in Sweden, at the moment.

Those cultures with high societal norms, i.e., Italy, do consume alcohol, but still have low rates of alcoholism. Those norms are enforced not by the government nor the clinicians. They are enforced by family and family structure. In North America, we not only lack a consistent attitude toward intoxication, we are not well known for having such strong family structures that can maintain values such as no intoxication.

We personally don't oppose people who want to experiment with controlled drinking programs. I think they are few in number in this country. Those that do exist tend to be university-based. I think with the interest of academic freedom and pursuit of science they probably should continue to exist.

Then, finally, at least in the Midwest, people seem to have an attitude that if you want to drink, that's fine. If you can't drink without trouble, then don't drink.

Increase NIAAA Funding: We would strong support increased funding for NIAAA for data collection, prevention, psychosocial research, etc. There are a number of national research centers already funded by NIAAA. Women's issues clearly are important. I don't know that one national center needs to be established to address those issues. Perhaps they could be addressed along with all of the other importance issues that need to be addressed. A project that NIAAA might do well with is the one of treatment matching/levels of care.

Federal government maintenance of a mandatory database of publicly-funded clients. We badly need more national data, in general. I think it is a serous limitation to limit it to publicly-funded clients and will result in a seriously biased sample and a slanted picture of treatment outcomes. I'm sure that the data is collected by many of the single state agencies. It's always been a mystery to me of what they do with it. And, on the other hand, NIAAA has published some very useful reports, i.e., their Report to Congress. At this point in time, I don't think anyone knows exactly how many alcoholism and drug treatment beds exist in this country. So, simple data such as that would be most informative.

Your time and interest in this effort is appreciated.

If I can be of further assistance, please let me know.

Sincerely,

Harold A. Swift

Harold A. Swift, ACSW, FACATA
President

HAS/phb

Enclosure

cc: Dr. Eileen Choffnes

Executive Summary of Research on Treatment Evaluation and Patient-Treatment "matching" in Alcohol/Drug Dependence

A. Thomas McLellan, Ph.D.
Director of Clinical Research, Philadelphia VA Center on Sustance Abuse Treatment and
Professor, Department of Psychiatry, University of Pennsylvania

a) Substance abuse treatments are demonstrably effective. A summary of eleven controlled studies performed in the Veterans Administration and in other clinics revealed that treated alcoholics have shown average **decreases of 61% in the amount and frequency of their drinking** and average **increases of 78% in their employment earnings** in the year following treatment. Similarly, treated drug abusers have shown average **decreases of 58% in drug use and 67% in criminal activity**, as well as **increases of 55% in employment earnings** in the year following treatment.

b) Substance abuse occurs in conjunction with other serious medical, psychological and social problems. These problems may be caused by or result from substance abuse - but if these problems are not addressed in conjunction with the substance abuse treatment they leave the patient at increased risk for relapse. At present, few treatment programs have the professional resources to focus on anything except the addiction. Research is accumulating which shows that the addition of appropriate professional interventions such as marital/family counselingfor associated family problems, psychiatric care and medication for associated emotional problems, employment/skills training to increase self-support - can enhance and extend the benefits from standard alcohol and drug abuse treatments. In this regard, it will be especially important to attract and train an infrastructure of professionals to deal with these and other problems of addicted people. This may be the single most important goal in the continued efforts to prevent and treat substance abuse.

c) The number and severity of patients' "alcohol-related problems" can predict outcome from different treatment intesities (eg. inpatient vs. outpatient). Patients with better social supports and fewer psychiatric problems do equally well in inpatient or outpatient interventions. Treatment of these patients in outpatient care is **7 to 10 times** cheaper than inpatient care of the same type. Patients having more serious psychiatric problems and/or fewer social supports do less well in most treatments but particularly poorly in outpatient care.

d) Patients can be matched to treatments. Studies performed within the Veterans Administration have shown that by using standard patient background information, patients can be assigned to the most appropriate and cost-effective treatment in a six-program treatment network. "**Matched**" patients had significantly better outcomes at six-month follow-up and were less likely to return to treatment than "**Mismatched**" patients treated in the same programs by the same staff. This matching resulted in an overall improvement in treatment efficacy of **37%** over an already effective treatment network and resulted in a **savings of over $3700 per patient**.

e) There is a need for more innovative interventions. In particular, there has been a concentration of research attention and treatment dollars on the **initial detoxification/stabilization phase of care**. Much less attention has been devoted to the **post-treatment adjustment and** integration of the patient into society - yet this is the point at which patients have the most trouble and are most at risk for relapse. There has been a tremendous amount of research in the treatment of alcohol and drug dependence over the past two decades but very little of it has translated into modifications of the basic treatment process. In some quarters the suggestion that new treatments are needed has been considered defamation of existing methods. In fact, there is every reason to feel heartened by the efficacy shown by existing treatments. However,the results of treatment evaluations and patient-treatment matching studies to date indicate that no single treatment is effective for all patients; that many patients have been admitted to inpatient treatments when short-term, less intesive/expensive treatments could have worked; and that many other patients will not accept or benefit from existing interventions.

Patient-Treatment Matching and Outcome Improvement In Alcohol Rehabilitation

Testimony presented to the United States Senate Committee on Governmental Affairs - June 16, 1988

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INTRODUCTION

In the years since the 1980 report of the IOM on the treatment of alcoholism there has been a substantial amount of work generated that pertains to patient-treatment matching. Perhaps most importantly there has been recognition that the idea of matching patients and treatments is a particularly sophisticated and difficult problem. Thanks in particular to the work of Glaser (1980), Skinner (1981) and more recently Finney & Moos (1986) the field has gradually accepted the facts that:

1) "matching" studies are among the most conceptually, methodologically and practically complicated of all the various forms of treatment evaluation research; and

2) truly appropriate studies of patient-treatment matching can only be accomplished once careful, parametric work on both patient and treatment characteristics has been performed.

Given this level of conceptual progress, work has continued in the past decade to investigate basic patient characteristics that are generally predictive of outcome across a variety of treatments. Treatment methods have begun to be better specified and to be applied in the manner specified. Finally, there has been progress in the development and utilization of appropriate designs to study the patient and treatment characteristics with sufficient power to observe "real" effects and using statistical treatments that can adequately assess the complexity of the various interactions.

In general then, there has been substantial accomplishment in the matching area over the past decade particularly in the areas of methodological development, patient measurement and treatment measurement. Therefore, in the first section of this paper, progress in each of these areas is summarized and general suggestions for research opportunities are presented. Here, the review articles by Miller & Hester, 1987; Annis, 1987; and Longabough, 1986 have been particularly helpful and the reader is encouraged to seek these sources for additional information and references.

In the years to come, it seems clear that additional progress in the matching area can be expected, particularly given the developments of the past decade. A review of the concepts, methods and results of the existing studies has suggested ideas for more focused designs and clearer evaluation questions tailored to the reasonable expectations of the treatments studied. These potential areas of advancement are discussed in the second section of the paper, along with more specific research opportunities.

SECTION I - GENERAL ADVANCES IN PATIENT-TREATMENT MATCHING RESEARCH 1978-1988

A. ADVANCES IN RESEARCH METHODOLOGY

The past decade more than any other has seen increases in the deployment of rigorous, experimental designs to assess treatment efficacy as well as the development of new and more sophisticated statistical procedures to analyze multiply determined outcomes.

Much of what passed for patient-treatment matching studies in the 1960's through the late1970's had been simply retrospective examinations of laundry lists of variables collected at the time of admission, on samples of patients admitted to two or more programs/treatments; generally using a series of t-tests, chi-squares or simple correlations.

Some of the progress in method development is due to the relatively recent (past ten years) practice of analyzing multiple outcome measures (eg. amount, duration and frequency of alcohol consumption, employment, social adjustment, medical services utilization) rather than just abstinence/non-abstinence in the evaluation of alcoholism treatment efficacy. This practice has promoted the recognition that "outcome" is not unidimensional and that many aspects of the patient's post-treatment condition (employment, family, psychiatric, medical) can have a direct bearing on the likelihood of relapse. Of course this was always "realized" by clinicians and researchers at some level but the concentration on simplistic, unidimensional outcome measures gave artificial simplicity to the treatment process and to the factors that accounted for treatment failure. The measurement of multiple outcomes encouraged researchers to give more thought to what exactly were the goals and reasonable expectations from various types of treatments; and what "types" of patients could reasonably be expected to show change in each. This in turn has led to more theory-driven designs with better specification of the treatments and the patients in them, as well as testable hypotheses regarding outcome.

As Annis (1987), Finney & Moos (1986) and Longabough (1986) point out, these theory-driven designs having specific hypotheses based directly upon the underlying assumptions of the treatments and the characteristics of the selected patient populations; have been the designs most likely to show evidence of patient-treatment matching.

A second development that has helped the matching area and that is also related to the practice of evaluating multiple outcome measures, is the use of multivariate statistics. It is now rare that a published report will contain only a two-by-two chi square distribution of abstinent and non-abstinent frequencies in two treatment programs.

Based on the methodological advice of Skinner (1981) and Finney & Moos (1986) there is now recognition that the number and complexity of the interactions between patient pre-treatment characteristics, during-treatment factors and post-treatment environmental factors cannot be characterized without the sophisticated use of multivariate statistical procedures. The introduction of these new and developing statistical procedures into the field has also increased the rigor of measurement, the sophistication of the designs used and the specificity of the hypotheses tested.

Opportunities for Research in Method Development

It seems clear that much of the progress in our understanding of matching has come from the use of more rigorous methodologies and experimental designs. There is no doubt that this movement should be encouraged. However, there is an additional need to develop a range of rigorous, non-experimental designs to study this issue. Because several aspects of experimental designs (particularly random patient assignment to treatments) cannot be tolerated in some clinical settings, especially in for-profit settings. This in turn has had the effect of reducing the number and breadth of studies in this area - and possibly limiting the ability to generalize conclusions from the available studies.

With the exception of a few innovative and opportune studies there have been few evaluations of patient treatment matching outside of public or institutional settings and these settings usually treat predominantly lower socioeconomic strata patients. Given the importance of social supports/stability in determining outcome across a variety of treatments, it may be that some of the matching conclusions reached to date pertain only to a limited segment of the patient population.

What has been perceived by some researchers as resistance to evaluation on the part of clinics and clinicians, is more often the pressures of ethical and financial exigencies in the real world. Many private clinics would truly like to participate in this type of evaluation but have been prevented because of design limitations. Several strategies may be investigated in the future. These include:

* A re-examination of Ewing's Cafeteria Matching strategy (Ewing et al., 1977) - where patients are offered several different alternatives and are permitted to select among them. The major limitation here is that the attractiveness of treatment is assessed along with efficacy, rather than efficacy alone. Attractiveness has been shown to be a big factor in determing retention in treatment and acceptance of treatment goals (Miller, 1985; Sanchez-Craig & Wilkinson, 1987) and it may be naive to think that this doesn't play a part in random assignment studies.

* Use of feedback designs that employ early findings to generate testable hypotheses that, in turn generate self-correcting additional hypotheses (Glazer, 1980; McLellan et al., 1980; 1983). Here patients are evaluated pre and post treatment within a multi-program network, with no modification to the standard patient-program assignment. Data are analyzed on this stage of the design and patient-program "statistical hunches" are developed based on the retrospective data. In the second stage of the project patients are assigned (based on the hunches) to the programs that may be "best" for them. Data are again analyzed and "matched" patients are compared against "mismatched" patients. Limitations here include the influence of the self-selection process, the need for adequate variability in program characteristics and the need for a relatively stable treatment network.

* Use of experimental designs to test the "addition" of a critical treatment element to treatment as usual. This strategy can be effective where there is a minimum standard treatment available for all (eg. bibliotherapy, brief counseling) and the addition of a specific therapy or medication can be tested against placebo or attention control. Since no patient is denied standard treatment and since participation in this type of study can lead to extra care these designs are often well accepted by both patients and treatment staff. Limitations here relate only to sample sizes that can reasonably be generated and the types of treatments this design can be used for (eg. does not seem appropriate for studying different programs or settings).

These types of designs may enable the matching research to continue in settings, treatments and populations that haven't been studied; and they may allow research findings generated thus far to be more easily translated into clinical practice.

B. ADVANCES IN PATIENT MEASUREMENT

The development of specified diagnostic criteria such as the DSM III (1980) and more recently the DSMIII-R (1987) have been major advances in treatment outcome research. DSM III was accepted by a majority of both clinicians and researchers in the field enabling better and more widespread interaction among them. Further, there has been the development of standard interview formats (SADS, DIS, SCID) that can produce these diagnoses reliably and validly. These developments have enabled researchers to achieve much more accurate and homogeneous groupings of patients than in prior years.

During the past decade there has been greater acknowlegement of the full range of problems that are typically seen among alcoholics presenting for treatment and there have been a number of groups that have developed measurement instruments to assess these problems, both at the time of treatment admission (as predictors of treatment outcome) and at follow-up points (as outcome criteria). As discussed by Finney & Moos (1986) the acknowlegement that the social, psychological and economic problems of alcohol dependent patients may be contributors to relapse and as such, targets of interventions during alcohol treatment, has broadened the scope and complexity of treatment evaluations.

Several groups have taken advantage of these developments in patient measurement to continue the search for generic patient variables that may be broadly predictive of outcome across several different types and settings of treatment. This is a rapidly increasing area of reserach to review and space limitations do not permit detailed examinations of all studies. Again, the interested reader is encouraged to acquire the review articles by Miller & Hester, 1987; Annis, 1987; and Longabough, 1986 for more detailed information.

However, this reviewer's reading of the literature suggests four areas/types of measurement that appear to be generally predictive of treatment outcome as evidenced by replication in more than one treatment setting and more than one type of patient population :

1) Social stability/social supports. Fewer supports = worse treatment response generally (especially from outpatient treatments). This factor appears to be the major, generic predictor of outcome across a variety of outcome domains. Azrin et al., 1982; McLellan et al., 1983b; Longabough & Beattie, 1985.

2) Psychiatric severity/number,duration,intensity of symptoms. Worse severity = worse treatment response generally (especially from outpatient treatments). This measure of overall impairment (irrespective of diagnosis) has been a good predictor across variety of outcome domains and patient populations. McLellan et al., 1983 a&b; Babor et al., 1987; Rounsaville et al., 1987; Cooney et al., 1988.

3) Severity of alcohol use/severity of the alcohol dependence syndrome. Greater severity = worse treatment response generally (especially outpatient), more rapid return to drinking, more rapid reinstatement of drinking problems. This variable has probably been the best predictor of post-treatment alcohol consumption and alcohol-related problems, although somewhat less effective as a predictor of adjustment in other areas (eg. employment, medical health, family relations, etc.). Orford, 1976; Polich et al., 1980; Lyons, 1982; Babor et al., 1987.

4) Anti-Social Personality Disorder. Presence of ASP is generally indicative of poor treatment response across all modalities with the possible exception of enforced disulfiram treatment. Stabenau, 1985; Powell & Pennick,-1986; Schuckit, 1984; Hesselbrock, 1985.

There are of course other patient variables that have been related to treatment outcome in several studies. These include presence of a family history of alcoholism (particularly first-degree relative) (Schuckit et al. 1985-1987; Goodwin et al. 1982.); presence of cognitive and/or information processing problems (Tarter et al., 1983; Walker et al., 1983) and others.

Opportunities for Research in Patient Measurement

Although it is encouraging that there has been a great deal of replication of these generic "patient predictor findings" and that they are all conceptually sensible and potentially clinically useful:

*a great deal more parametric work must continue to determine the strength of these variables across a variety of patient mixes and treatment types.

*more work must be done to determine the extent to which these more robust predictors covary, especially in selected segments of the population. For example it is possible that high alcohol dependence, ASP and history of familial alcoholism may occur in conjunction, especially in chronic, male alcoholics.

*the DSMIII-R differs in major ways from the DSMIII and it will be important to determine if these differences relate more or less to patient outcome from a range of treatments.

* with the exception of Antisocial personality disorder, there has been very little evidence that the presence of a *specific* psychiatric disorder is predictive of treatment outcome (global symptom severity has been more predictive than specific diagnosis).

It may be that a particular type of treatment must be developed to address the specific needs of certain diagnostic groups (eg. depressed alcoholics, alcoholics with panic disorder) before matching will be possible. In addition, work is needed to better define and describe the dimensions of Antisocial personality disorder (eg. impulsiveness, learning disorder, relationship formation problems, crime, etc.) to determine the nature of the resistence to treatment.

*motivation for change is widely viewed as an important predictor of response to treatment yet there has been little indication that this quality can be measured reliably or validly. A clear definition of motivation (avoiding circularity with treatment response) and a means of measuring it would be valuable. In this regard the recent work of Prochaska and his associates in measuring the "readiness for change" will be important to pursue (Prochaska and DiClemente, 1985;1986).

C. ADVANCES IN TREATMENT MEASUREMENT

The past several years has seen the development of several new treatments such as the Relapse Prevention model (Marlatt, 1985; Gorsky, 1982); the development of structured, brief interventions (Miller, 1985; Sanchez-Craig, 1982) and the wider use of standard treatments in different settings (eg. outpatient detoxification, wider use of outpatient forms of rehabilitation). In addition there has been development and implementation of manual-directed treatments in the areas of Relapse Prevention (Marlatt, 1985) and self-help treatments (Heather,1986; Miller, 1986). These are particularly welcome developments for a variety of reasons. First, the manuals are an important source of training in theory and practice, thus promoting standardized delivery of the treatment. In addition, these manuals have been valuable to researchers, enabling them to derive better measures of treatment goals and treatment process.

Opportunities For Research in Treatment Measurement

Despite important progress in the area of treatment process standardization there has been much less development in the area of during-tretment measurenent.

*New treatments are needed for specific segments of the population such as the cocaine-alcohol dependent patient, the antisocial personality alcoholic, the alcoholic schizophrenic and the medical patient with an alcohol-related disorder (eg. alcohol cardiomyopathy, alcohol hypertension, etc.)

These should be conceptually related to the specific problems of the targeted patient populations; and manual-guided to insure accuracy of their application. While this is somewhat off the subject of patient-treatment matching, it seems important to mention in this context in that matching can only occur under conditions where there are clearly different treatments. So many of the treatments in practice are simply variations on a few themes. There is no available evidence at this time that any single process or approach will work for every patient and newer methods may have success where others have failed.

* There needs to be the same attention paid to developing a *treatment measurement instrument(s)* as has been paid to the development of patient measurement instruments.

The conclusion is regularly voiced that patient characteristics account for more variability in outcome than treatment characteristics. Could this be in part a function of the lack of treatment measures available (Glaser, 1980)? The development of treatment manuals for specific therapies has promoted criterion-based measures of the extent to which treatments have been delivered as intended, the quantity of the treatment provided to a patient and ratings of its quality. Work using these manual-derived process measures has been started (See Luborsky et al., 1985) and it has been revealing. However, it is tedious, expensive and lacking standardization or general use. A more basic instrument that could be useful to a variety of treatment programs in the field would be worthwhile to assess the nature and amount of various treatment "ingredients" actually received during treatment. This in turn could begin to provide indication of which of these "ingredients" are important as well as suggestions as to how to train and improve the delivery of these ingredients.

The lack of such an instrument has handicapped the study of matching and even the accurate evaluation of treatment efficacy since we are still not sure about embarassingly basic questions regarding treatment effects. These questions form the basis for several important research studies:

*What is treatment supposed to do? Many insurance companies and treatment funding agencies have reduced the amount of time they will reimburse for alcohol rehabillitation from 90-120 days down to 28 or 30. Have the goals of treatment changed to reflect these time constraints? Are the goals of rehabillitation clearly different from detoxification - do they build upon each other?

* Have patients reached the established goals of treatment by the time they are discharged/released? There are few studies (my own being prime offenders) evaluating progress during the course of treatment. Maybe treatment doesn't result in post-treatment change when there is no during-treatment change?

* How much "treatment" does it take to produce a 50% (for example) change in goal "X" for 75% of patients? It seems that we must begin to move toward a more quantified estimate of treatment effects so that more informed decisions can be made regarding how much treatment should be compensated.

*Does the achievement of the during-treatment goals relate to post-treatment success? There are beginning to be more studies of this nature, especially following the work that Finney and Moos have done showing the importance of the post-treatment environment. However, even these excellent studies still lack the specificity of measurement necessary to determine if the "treatment" is applied in the intended manner and to an adequate extent.

* What are the "active ingredients" of treatment? Treatment programs offer many services/interventions. For example in the excellent study by MacLachlan &Stein (1982) patients received a standard treatment package consisting of:

medical consultation
disulfiram or calcium-carbimide
group psychotherapy
education
relaxation training
nutritional counseling
physiotherapy
physical training/exercise
individual planning for alcohol-free lifestyle

Are all of these necessary? Are they all associated even remotely with outcome? What are some of the essential or "active ingredients"? This area of measurement is particularly related to matching in that investigators (particularly me) have been attempting to match people to treatment settings (inpatient and outpatient); or treatment programs (specified very loosely) without knowing or even presuming the factors that may be responsible for the observed patient changes.

Thus even when conclusions have been tendered that "an outpatient treatment setting is effective for this type of patient.." or "Program B is effective with that type of patient..." it has not been possible to specify why that might be or what has been responsible for the effect. For this reason it appears critical for treatment outcome studies and patient-treatment matching efforts in the next decade to focus on the treatments provided as well as the patients treated in order to advance the field.

SECTION II - POTENTIAL ADVANCES IN PATIENT-TREATMENT MATCHING RESEARCH 1988-1998

Given the advances of the last decade in the fundamental areas of method development, patient and treatment measurement, what can be expected in the years to come in the area of matching research? The results of this review suggest that the most potential for advancement will come from the analysis of more discrete and better defined stages of the rehabilitation process; from the process of treatment selection through the provision of specific treatment components during rehabilitation, to the services offered in the post-treatment environment. Just as each of these stages of the rehabilitation process has a different context in which it takes place and a different set of goals for the patient; the clinical possibilities for patient-treatment matching and the potential for matching research will also be different. Therefore, the remaining portion of the paper examines the potential for matching research in each of four areas that coincide with the typical context in which treatment is provided. In each of these parts there is critical commentary regarding the matching research done to date, suggestions for future methods to be applied and examples of specific types of studies that could be performed.

A. MATCHING BEFORE THE TREATMENT STARTS: Special Populations and Self-Selection -

In an ideal world the outcome evaluation researcher could examine the effects of a representative treament program, technique or modality on randomly selected patient samples, that would in turn, proportionately represent the relevant segments of the total patient population. In fact, the world is not an ideal place for the treatment outcome researcher and the results of virtually all outcome studies done to date reflect imperfectly applied treatments in non-representative, self-selected patient samples (usually the most severely impaired patients). This is important in that conclusions from these results are often discussed in terms of what they mean to "the treatment community" or to "the alcoholism field."

In fact, the population of alcohol-dependent individuals is not well represented by the samples of patients that present for treatments. Further, because the nature of the treatment program (including its location, cost, referral network, charter and preferred modalities) will determine in large part the types of patients who present for treatment; the sample of patients evaluated at a specific treatment program will not even be representative of the population of treatment-seeking, individuals.

Of course, treatment programs have recognized and utilized patient self-selection in their marketing strategies and in their clinical attempts to "...develop programs tailored to the individual needs of the patient...." This process of solicited self-selection is sensible in that it is not likely that the effects of even conceptually identical, comparably applied treatments would be similar for a sample of older, male, lower socioeconomic, chronic alcoholic veterans treated in a VA hospital; and a sample of adolescent, middle-class, girls referred to treatment early in the course of their substance abuse carreers at a private facillity.

This means that *a form of matching takes place prior to the initiation of treatment*, through the process of specialization (ie. programs for adolescents, Native Americans, women, etc.) and the selective marketing and referral for "seemingly appropriate" patients. This is by far the most extensive and possibly the most relevant of all the matching work done in this country, yet little more than descriptive information is available on this level of effort.

OPPORTUNITIES FOR RESEARCH AT THIS LEVEL -These "facts of clinical life" do not imply that research in this area is impossible. On the contrary, matching or prediction of outcome studies are well suited to ongoing treatments as long as the questions addressed and the methodologies employed are conceptually suited to the context in which treatment occurs. For example, studies could be carried out to address the following questions for programs designed with specialized segments of the patient population in mind:

* Do the patients with the "right" patient profile stay longer, show more improvement, and remain improved longer than patients with the "wrong" profile?

* Is greater demographic and socioeconomic homogeneity among patients associated with better retention in a specific treatment, ie. how much and what types of diversity can a patient population tolerate and maintain cohesiveness?
This is relevant to the increasing amount of cocaine and alcohol use found in patients presenting for treatment at traditional alcohol programs - can these patients be treated with alcohol-only patients? Are the treatment goals and methods compatible for these two types of patients?

* Do similar treatment strategies (eg. abstinence vs. controlled drinking) and components (eg. group therapy, education, AA, antabuse) have qualitatively similar effects on outcome among programs with different patient profiles?

* Do two conceptually and methodologically different treatments tailored to the same patient profile have differential effects?

B. MATCHING AT THE INITIATION OF TREATMENT: Levels of Treatment Intensity - There are at least four levels of treatment intensity that are offered in most areas and have been studied:

1) Advice/Self-Help
2) Brief Interventions (usually counselor appointments lasting less than a week)
3) Outpatient or Partial Hospitalization
4) Inpatient Care (either at a rehabilitation facillity or as part of a hospital).

Table I describes available results from matching or prediction-of-outcome studies done to date. Not all pertinent studies are represented in the table, just those that are more carefully conceived and controlled. Blanks indicate the absence of a representative study or conclusion (I'm sure I've missed some and corrections are gladly accepted). Other, very useful tabular presentations of similar data include those of Longabough (1987) and Annis (1987).

While there are several points of interest in this table, one methodologically significant point is that the patient factors that are predictive of treatment outcome at a reduced level of treatment intensity (eg. none or brief treatment) *usually continue to be predictive even at more structured levels of treatment*.. As can be seen, social and economic factors have been reliably associated with post-treatment outcome in studies at all levels of treatment intensity.

Table I
A Proposed Hierarchy of Treatment Interventions and Their Known Outcome Predictors

Patient Characteristic	*Treatment Characteristic*	*Representative Publications*[1]
I Factors suggesting improvement without any treatment		
Low ADS		Vaillant,83;86
High Social Supports	Not Applicable	Tuchfeld,81
(Married, Job)		Elal-Lawrence,87
II Factors suggesting improvement with only brief treatment		
Low ADS	Informative/instructional	Sanchez-Craig,84; 87
High Social Supports	Controlled drinking goal	Miller, 85; Orford, 77
	Anonymous	
III Factors suggesting improvement within traditional outpatient programs[2]		
All of the above predictors plus:		
High Social Supports	Length of stay	Armor, 76; Willems, 73
Low Psychiatric Prob		Finney, 81;McLellan,83
Low ADS		
IV Factors suggesting improvement within traditional inpatient programs[2]		
All of the above predictors plus:		
Mid to High ADS	Length of stay	Armor, 76; Willems, 73
Mid to High Social Supports		Finney, 81;McLellan,83
Mid Psychiatric Prob		
V Factors suggesting no improvement within traditional programs[2]		
High Psychiatric Severity		Stabenau, 85;Woody, 85
High ASP		Powell,86
VI Factors suggesting maintained improvement following treatment		
Low ADS	Attend AA	Moos,80; 83; Azrin, 76
High Social Supports	Relocation	
Low/Mid Psych Sev.	Structured Aftercare	MacLachlan, 74

[1] Studies are referenced if they pertain to either patient or treatment characteristics

[2] "Traditional" treatment programs are recognized as combinations of a variety of methods and ingredients - the active ingredients of these programs are not presumed at this time. Table II illustrates several commonly employed ingredients and the predictor studies pertaining to them.

The questions that have been asked to date regarding these treatment levels have been principally economic in origin. What patient factors predict favorable outcomes in these treatment levels? Is one of these treatment levels significantly better than another for randomly selected groups of patients? The methods usually used to address these questions have been random assignment to two or more levels of care and evaluation at points during and following treatment. While this type of design is quite appropriate for an overall determination of cost-effectiveness in the population at large, the use of an explicitly experimental design, employing random patient assignment, *where treatments of different intensities are evaluated simultaneously*, may not be completely adequate for examining the patient-treatment matching question.

For example, consider a matching study where the investigators are interested in the factors that predict better outcome in two clearly different levels of treatment intensity (eg. inpatient vs outpatient rehabillitation). Being good methodologists these investigators randomly select and assign patients to the two treatments. The results indicate that the most general of all the predictive factors (eg. social stability) will overshadow all the other potential predictors (such as type of therapy, length of treatment stay, patients' information processing ability, etc.) leading to the conclusion (very often reported, eg. McLellan et al., 1983) that patients with more social and economic supports do better in both treatments, but significantly better than less supported patients in outpatient treatment. While the conclusions resulting from such a study would be technically "correct" they might not be useful in the real world situation and they may under-represent the effects of patient and treatment variables that have been overshadowed by the social support factors.

As was discussed above in the section on program recruitment and patient self-selection, these pre-treatment factors generally combine purposively to produce a more restricted, homogeneous and (hopefully) appropriately "matched" patient sample than would be found through random selection and assignment. For example, one usually (obviously not always) finds more severe alcoholism, fewer social supports and more medical problems among inpatient populations than among outpatient populations. In fact, as has been discussed above, most outpatient programs solicit well-supported patients and tailor their treatments to that group. In a "real world" examination of these treatment settings the social stability, marital status and other "overriding" factors might be less important statistically (due to the reduced variability) and clinically (due to patient self-selection) than other patient and treatment factors. Further, it might not be useful for an inpatient program director to know that more socially advantaged individuals will do better in his treatment - what does he do with the socially disadvantaged patients that may make up the majority of his population; and what factors (that he can exert some control over) are predictive of outcome once social stability is partialled out of the picture.

Thus, the most tightly controlled and rigorous of the patient-treatment matching designs may run the risk of producing the least clinically relevant data. This is the classic distinction between internal and external validity. The best internal validity will be achieved in well controlled, random assignment studies that would enforce greater variability across a range of patient characteristics (in both of the programs studied) than would be experienced under normal conditions of patient self-selection. This in turn, has the effect of compromising the external validity (ie, generality and value) of the conclusions.

RESEARCH OPPORTUNITIES AT THIS LEVEL - It seems that there is now a body of valid, replicated data regarding general patient factors in treatment matching; and enough conceptual clarity regarding the various levels of treatment, that more carefully staged designs are now possible. Staged or hierarchical designs refer to the tailoring of matching hypotheses to the treatment goals and patient populations appropriate for different levels of treatment structure (no treatment, brief treatment, outpatient, inpatient). All this really means is that new work in this area should build on those conclusions from the past several years that have been replicated and that make sense. The work of many investigators (see reviews by Miller & Hester (1986) and Annis (1986)) indicates that individuals component (medication, therapy, education, etc.) level and even less at the therapist or counselor technique level. This is potentially important in that the failure to find evidence of matching between different programs or settings may be due to the similarity of the therapeutic methods employed between treatment programs and settings. Again, this highlights the need for more detailed measurement of the treatment process and examinations of what are the "active ingredients" of treatment. If these active ingredients are at the process level and if they are applied fairly similarly across treatment settings and programs, then it should not be surprising that there would not be much evidence of "patient-setting" or "patient-program" matching other than at the grossest levels (eg based on levels of social supports, psychiatric severity, etc.).

Table II
Predictors of Improvement in Programs Using the Following Components

Patient Characteristic	***Treatment Characteristic***	***Representative Publications***[1]
Antidipsotropic Medication		
Low social stability		Mayer, 71
Married		Azrin, 82;Fuller,83
Not depressed		Keane,84
Group Therapy (Note: there are many varieties of therapy, predictors may not generalize)		
Conceptual level	Therapist empathy	MacLachlan, 74
High self image		Annis,83
Individual Therapy (Note: there are many varieties of therapy, predictors may not generalize)		
	Therapist empathy	Luborsky, 85;
	Technique "purity"	Sanchez-Craig, 87
Aversion Therapy		Miller, 87
Relapse Prevention		
Diff. env. risk		Marlatt,85;Gorsky,82 Annis,87
Lithium		
Depressed		Merry, 76
AA		
Authoritarian/religous		Ogborne,85
conforming		Hurlburt,84
non-depressed		Brandsma,80
Alcohol Education		Kinder,80
Social Skills Training		Botvin,84

[1] Studies are referenced if they pertain to either patient or treatment characteristics

RESEARCH OPPORTUNITIES AT THIS LEVEL -

*random patient assignment methods in controlled experimental trials can be most profitably used in studies within a treatment setting or program to investigate the with less severe and shorter periods of problem drinking, better social supports and fewer medical and psychological problems can improve from alcohol problems without intensive treatments. Therefore:

* studies of matching *between* different levels of treatment intensity should attempt to select patients with approximately the same levels of treatment problems and social supports. For example, in a study of inpatient versus outpatient treatment it would be preferable to include only those patients who were considered (based on clinical and research data) appropriate for outpatient care. Results might then permit a better understanding of the patient factors within the "clinically appropriate" group that are associated with favorable and unfavorable outcomes from each level of treatment intensity.

* studies of matching *within* each level of treatment intensity are needed to evaluate the treatment components (eg. group therapy, individual therapy, medication, education, etc.) and patient characteristics (from within the clinically appropriate group) that are associated with favorable outcome.

*Norman Hoffman's model of patient assignment to different levels of treatment intensity (Hoffman et al., 1985;1986; 1987) should be evaluated in a series of controlled evaluations at various sites and with various segments of the patient population. This patient assignment model has been carefully thought through, offering face valid ideas for appropriate levels of care and clear improvement criteria for transferring patients between these levels. This is a very promising and practical approach to an important and expensive problem confronting prospective patients, treatment providers and third party payers; but it has not received systematic research attention.

C. MATCHING DURING THE TREATMENT PROCESS: The Role of Treatment Components - There are a fairly discrete set of treatment components that are provided or at least available to most alcohol dependent patients in treatment, regardless of the modality or setting. These include:

1) Group Therapy (usually focussed on issues of treatment need and denial)
2) Individual Therapy (usually personal counseling re: relationship problems and crises)
3) Alcohol or Substance Abuse Education
4) Alcoholics Anonymous - 12 Steps (either as part of the treatment or through referral)
5) Anti-Dipsotropic Medications (usually Disulfiram).

Table II presents a series of treatment methods, as well as the patient and treatment factors that this review has found to be associated with outcome. Please note as discussed above that while there has been at least a moderate amount of work looking at matching in treatment settings (inpatient vs. outpatient) and among programs, there has been little matching work done at the treatment value of different combinations of treatment components or the addition of a specific component to treatment as usual. Woody's study of psychotherapy as an adjunct to standard counseling (Woody et al. 1984; 1985) is an example of such an approach that can provide clear data on the worth of specific treatment components. Virtually all of the standard treatment components now used in rehabilitation programs (education, 12-steps, group therapy, etc.) could be evaluated for their contribution to outcome across various treatment settings and patient populations using this method.

* the treatment *methods and techniques* that have been predictive of favorable outcome in less structured treatments (eg. individual therapy, non-confrontive approach, patient participation in treatment goals), are typically not those used in the more structured treatments (eg. group therapy, confrontation, program directed goals). There may be a very good reason for this but there has not been much research in this area that supports the differentiation. More research is indicated here.

*The order in which various treatment components are presented during the rehabilitation process would also be important for study. Is it better to present alcohol educational material early in the course of treatment (as is typically done) or to present it following successful confrontation of denial and stabilization of cognitive function? Should relapse prevention strategies be used to initiate treatment or should they be instituted at the point of aftercare?

D. MATCHING FOLLOWING PRIMARY REHABILITATION: The role of the post-treatment environment In the past, the post-treatment environment of patients was a direct function of the pre-treatment resources of the patient, since most programs have concentrated upon primary care and have not had the resources to develop tailored post-treatment arrangements. Further, the continued treatment possibilities offered to patients who had completed primary care have been generally restricted to AA and possibly a weekly or monthly continuing care meeting at the primary care site.

RESEARCH OPPORTUNITIES AT THIS LEVEL - The work of Finney and Moos (1985) has shown that the effects of the post-treatment environment can exert profound influence on the overall outcome of treated alcohol abusers. Because of this work, the ever reducing length of reimbursed care in primary rehabilitation and the financial push toward outpatient treatments; clinical programs have devoted more time to development of post-treatment "continuing care programs" and have attempted to bring the families of the patient into the continuing treatment process. With the addition of these available services comes the opportunity for patient-treatment matching reserarch following the period of primary rehabilitation.

*comparative studies of AA, relapse prevention, individual therapy, and/or family therapy following completion of primary rehabilitation could be initiated in a variety of treatment settings and patient populations. Do these interventions add anything to primary care alone? What types of patients can benefit differentially from each of these? Ideally these should be parametric studies investigating the optimum duration and intensity of treatments and they should include measures of cost-effectiveness.

*comparative studies of different post-primary care environments could be conducted to determine their overall efficacy and the types of patients differentially suited to them. Examples of these environments could be half-way houses, quarter-way houses, family treatment centers (these are essentially hotels that provide environments for the family to jointly work out treatment issues facing the whole family).

*comparative studies of family treatments (independent of the patient) could evaluate the contributions of various forms of family education on the post-treatment adjustment of the patient. For example, during the course of the patient's rehabilitation, families could be assigned to Alanon, family therapy, alcohol education, or individual counseling. This post-treatment ennvironment focus could help to determine if these interventions add anything to simple primary care for the affected patient; and if these differentially focused approaches could be matched to specific types of families.

CONCLUSIONS

1. The work to date on patient-treatment matching has been productive and has suggested three conclusions:

a) patient factors have been more predictive of outcome from treatment generally; and of differential effectiveness of specific treatments, than treatment process factors. However, techniques for patient measurement have shown major development in breadth, reliability and validity over the past decade. In contrast, treatment processes have been almost unstudied and there are no available instruments for reliable and valid treatment measurement (see below).

b) of the patient variables studied, psychosocial factors have been among the most important predictors of outcome from different treatment intesities (eg. inpatient, partial-hospitalization, outpatient). Specifically, patients with better social and economic supports and fewer psychiatric problems do well in most treatments and seem to benefit equally from inpatient or outpatient interventions. Lower socioeconomic strata patients and those having more serious psychiatric problems do less well in treatment generally but particularly poorly in outpatient care.

Patient factors such as severity of alcohol dependence, family history of alcoholism and presence of antisocial personality disorder have been generally predictive of poorer outcomes from all treatments; but not differentially predictive of response to specific treatments.

c) There have been very few studies of matching patients to different treatment components (eg. group therapy, individual therapy, medication, relapse prevention) within a given level of treatment intensity. There are at this time no clear predictors of differential outcomes from any of these components.

2. The matching work in the coming years gives every indication of potential for significant, practical advances. To this end, the following recommendations are offered.

a) As has been discussed by Annis (1987) and Longabough (1986) there is a need for more specific focusing of matching questions. Efforts should be made to study well-specified treatments, having clear therapeutic goals in specified segments of the patient population using theory dirven hypotheses (eg. lithium vs. cognitive-behavioral psychotherapy for depression in patients meeting DSMIIIR criteria for alcohol dependence and major depressive disorder). These types of designs offer a much greater likelihood of providing interpretable results; and where the mechanisms responsible for those results can be inferred.

As discussed here earlier, matching studies employing appropriate designs should be considered at each level of the rehabilitation process. At the level of referral to the treatment program (primary care) and of referral to the post-treatment environment (aftercare) it might be reasonable to consider non-experimental designs employing a cafeteria approach (Ewing, 1974) or a feedback system (Glazer, 1980). At the level of assigning treatment components or treatment providers within the program (the treatment plan), experimental designs with random patient assignment could be used to evaluate differential efficacy of components with approximately equal attractiveness and comparable intensity.

In this regard, efforts should be made to study the specific hypotheses regarding patient assignment to differing levels of treatment intensity suggested by Hoffman's recent formulation (Hoffman et al., 1987). This model offers a very good beginning for practical studies of the treatment assignment process.

b) There is a need for more innovative interventions and programs designed to address specific treatment problems in the population (eg. the psychiatrically ill alcoholic; the antisocial alcoholic; the cocaine and alcohol dependent patient, etc.). Similarly, there is a need to continue evaluation and patient-treatment matching work with recently developed treatments for problem dirinkers (eg. Miller 1985; Sanchez-Craig, 1987), for relapse prevention (Marlatt, 1985; Gorsky, 1982) and for community reinforcement (Azrin, 1982). As has been discussed by Skinner (1985) and others, it is difficult to study the optimum matching of patients and treatments when there is so little variability in the philosophy, duration or basic therapeutic components (eg. group therapy, alcohol education, AA/12-steps, recreation/relaxation) of most treatments.

There has been a tremendous amount of research in the treatment of alcohol dependence over the past two decades but very little of it has translated into truly innovative modifications of the basic treatment process (Miller, 1986). In some quarters the suggestion that new treatments are needed has been considered defamation of existing methods and philosophies. In fact, there is every reason to feel heartened by the efficacy shown by existing treatments (McLellan et al., 1982). However,the results of treatment evaluations and patient-treatment matching studies to date indicate that no single treatment is effective for all patients; that many patients have been admitted to inpatient treatments when short-term, less intesive treatments could have worked; and that many other patients will not accept or benefit from existing interventions.

c) Perhaps the clearest need within the area of patient-treatment matching is for the development of a reliable, valid, practical and generalizable instrument to measure the types, amounts and duration of alcohol treatment interventions applied to a patient during the course of rehabilitation. This is necessary for many reasons but primarily for training of therapists and evaluation of treatment efficacy. If treatments are not applied in a manner consistent with their philosophy then it is not reasonable to think that they will work. The simple fact is that we rarely know if even a specific intervention (eg. group therapy for denial), much less a multi-service treatment program, is practiced in the manner originally intended. We don't know the extent to which different individuals in a single treatment receive the same types, amounts or duration of treatment components. The often repeated claim that patient factors account for more outcome variation than treatment factors may simply be due to the lack of measurement presently available in the treatment domain. In the near future, the ablilty to characterize a treatment intervention or program in the same way that patients are now characterized will effectively double our present ability to predict outcomes and to optimally assign (ie."match") patients to available treatments.

QUESTIONS FROM SENATOR GLENN AND RESPONSES BY DR. McCLELLAN

1. Would you agree with the statement of Dr. McElrath that the Hazelden Program is the most successful treatment program in recorded history?

2. In your opinion, is the reason that people have an unsatisfactory response to treatment a result of their having failed to comply with the treatment conditions, had an inappropriate treatment given to them, or some combination of the two?

3. Health insurance providers, as well as Medicare/Medicaid, preferentially reimburse clients for hospital-based or residential alcoholism treatment. Your testimony would seem to suggest that the "best" treatment is often to be found in less intensive, non-residential settings. What are your recommendations to this Committee in shifting the emphasis of Medicare/Medicaid and third-party providers away from hospital-based treatment to less intensive, non-residential treatment settings?

4. How important is aftercare in the maintenance of sobriety once a person has been detoxified in primary treatment?

5. Why do you think there has been so little research in the United States on the value of behavioral self-control training in alcohol abuse treatment when it is the model for treatment in Europe?

6. Do you believe that abstinence as a treatment outcome goal is appropriate for all problem drinkers? If not, what categories of clients should have abstinence as a goal and what types of clients may be re-educated to non-problem drinking?

7. For any of the treatment components or strategies you discussed at the hearing, which strategies, in your opinion, are the most effective for prolonged periods of non-problem drinking?

8. A witness to one of our earlier alcoholism hearings recommended that NIAAA allocate increased funding for data collection, prevention and psychosocial research, and the establishment of a national research center on Women, Alcohol, and Other Drugs. How do you feel about this suggestion?

9. It has been suggested that the Federal Government maintain a mandatory data base on clients that use publically funded alcohol abuse treatment services. Do you feel that such data collection activities ought to be re-established as a formal, Federal mandate or should the data collection activities remain as they are?

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July 15, 1988

Dr. Eileen Chofness
Committee on Government Affairs
Room 340 Dirksen Senate Office Bld.
Washington D.C., 20510 - 6250

Dear Dr. Chofness,

I am sorry for the delay in responding to your additional questions - I was away for about three weeks. I have enclosed a copy of the questions that you sent. I will refer to them by number and will try to be brief and to the point in my responses.

1. Are you kidding? They have by all accounts (not research findings) a very well organized program at Hazelden and they are to be credited with influencing many other treatment strategists. They have no "recorded" evdience of treatment "success" assuming that we could all agree on what constitues treatment success. Like so many private programs, they screen out many patients that they feel would be inappropriate for their treatment. Let's suppose they have a 90% "success" rate with those who complete treatment. That's great. How many and what types of patients did they exclude to begin with? How many drop out - usually this is somewhere between 25 and 50% of those who start. Let's compare that with an average VA program for example, which treats a much lower socioeconomic strata and those with fewer supports and more psychiatric problems. The VA must accept all prospective patients. Given the same level of drop-out, this type of program may show a 70% (?) "success rate" with those remaining - which program is better?

No - I conclude from this careful analysis that **we** have the single finest program in recorded history and their's is second. There may be other programs with similar conclusions.

2. Usually treatment failure is a product of many things - most of which are related. Is the treatment philosophy one which the patient can accept? If it is accepted does the patient have the necessary motivational and social supports to carry through with the prescribed plan? Has the treatment plan been presented, described, justified and reinforced sufficiently to make the patient accept it?

Be wary of treatment failure explanations that place complete responsibility for treatment compliance on the patient (ie. he wasn't motivated for recovery; he hasn't "bottomed out yet," when he's **really** ready for recovery the treatment will work). I find these explanations (most of which are offered by treatment personnel) to be curiously insulting to the treatment process itself. Is it not a significant part of the treatment provider's job to instill motivation, to bolster doubt, to confront denial? As shown in the material I sent you there are big differences in compliance and outcome within a treatment program depending upon the particular counselor and/or group therapist that a patient receives. Clearly there are cases where patients who do not yet want to recover and this is largely up to them - however there are many ways to create failure or success and these generally involve multiple factors.

Do you think you'll ever get a simple answer from me?

3. I agree with Bill Miller's published work on this issue. As in most other medical conditions I think the provider should consider less intensive, restrictive or intrusive interventions first - prior to automatically prescribing the most intensive intervention.

By the way in work that we are just completing, looking at the number and types of treatment services actually provided by programs, we now see at least part of the reason why there is so little difference in outcome among inpatient and outpatient treatments. Despite the more restrictive and consuming environment of an inpatient setting - a majority of the inpatient programs that we examined actually provided no more services (eg. group and individual therapy, medical consultations, family therapy, psychiatric evaluation and counseling) than the outpatient programs.

4. All indications are that the post-treatment environment and participation in aftercare treatment is extremely important in maintaining during-treatment gains. AA and/or other forms of aftercare seem to function best in this way - by reinforcing changes that have already taken place.

5. I am sure about this. AA has done a tremendous amount of good for alcoholics and clearly offers hope and care to many treated alcoholics. Because of this they have developed a devoted, vocal and politically powerful following. Their very strong view is that there is only **one** way to treat alcohol abuse: AA - and that it involves complete abstinence; anything less constitutes immoral (yes, I mean immoral - this is a religiously held belief) action.

Most treatment practitioners agree that this philosophy is appropriate and therapeutic for those alcoholics who have demonstrated the inability to control their drinking and who have failed prior treatments. However, the figures show that AA attracts and holds approximately 25% of **treated** alcoholics; then there are the early stage drinkers and those who simply won't accept the religious orientation of AA (many of these patients are referred to as being in denial, not being ready for treatment or not "bottoming out"). There are indications from other countries and from some experimental studies here, that controlled drinking training may be helpful for these early stage drinkers and/or those who won't accept AA. This is seen by the AA-influenced treatment establishment as being immoral. This is very serious because it prevents the development of new treatments for patients and prevents even experimental questions from being asked (this occurred just last month at our National Academy of Science/IOM meetings re: alcohol research issues) since funding is often denied researchers who have proposed such questions. Again, it all stems from the conviction that AA is not only the best way to treat alcohol dependence, it is the **only** way.

6. Much of my response to this has been covered above. To expand, there is no clear answer to this at this time since much of the work in this area has been blocked. Indications are that early stage problem drinkers (prior to clear loss of control) may be able to learn controlled drinking goals. Further, there is indication that attempts at controlled drinking goals often lead to abstinence as outcomes. Particularly in private practice settings with individual counselors - patients have attempted to achieve controlled drinking goals as part of a general therapeutic approach. Results from their attempts have often been an important source of information for them in developing their ultimate behaviors. For example, patients who have failed controlled attempts have seen for themselves that abstinence is their only realistic goal (sort of early bottoming out); while others who have gotten control over their drinking have chosen to give up alcohol entirely as a means of attaining better overall health. I think this is interesting and it needs more study. Please note that these results come from private practice settings and not from formal treatment programs that cannot take the risk of censure by the AA-oriented establishment.

7. As I said many times at the hearing, alcohol and drug abuse rarely occur in the absence of other significant problems. The complicating thing about this is that these problems may have resulted from the alcohol/drug use; may have caused the alcohol/drug use; and/or may have nothing to do (etiologically) with the alcohol/drug use. However, if a patient is treated with maximal focus on the drug/alcohol problem and little or no attention to these other problems - all studies and clinical reports indicate that the continued post-treatment status of the patient is in jeopardy. Therefore, I favor the approach of first, getting the alcohol/drug problem under control and then concurrently evaluating and treating the economic, social and particularly psychological problems associated with the dependence. This strategy offers the best chance of achieving and maintaining **either** abstinence or controlled drinking goals.

8. I of course favor additional funding for the two substance abuse agencies NIAAA and NIDA since I believe that we are just beginning to understand the important elements of treatment and to identify the segments of society that have not responded to existing treatments.

There are four (I think) NIAAA Centers for alcohol study and three NIDA Centers for drug dependence. As I said at the hearing, these Centers (as well as all other aspects of the research program) have suffered not so much from lack of money as from wild variations in the money allocated - huge increases one year, major cuts the next. Moderate, stable funding is absolutely essential to build a cadre of researchers to make steady progress in some of these important areas.

With regard to additional funds for the study of women with alcohol/drug problems, I think this is particularly important for several reasons. First, women are much less likely to come into treatment programs than men - so they are unidentified. Second, it is likely (though not proven) that different treatment methods may be indicated for them. Finally, they have babies. The incidence of children born with alcohol and/or drug dependence is increasing dramatically and this may be the worst of all the problems that we face.

9. I must say that I don't see the need for such a data base. In the past the data has been very inaccurate and not very useful for research or even administrative use (see below). Second I would worry about the confidentiality of such information - it would be counterproductive if this data bank kept patients from comming to treatment. Thirdly, there are a tremendous number of alcohol abusing patients who actually receive government-based alcohol treatment as part of primary treatment for a medical disorder (as much as 33%) or for a psychiatric disorder (as much as 50%) or for a primary drug dependence disorder (as much as 65%) and these would not be recorded in the proposed data base. Finally, the proportion and characteristics of government treated alcoholics are not clearly related to the number and characteristics of all alcoholics - I'm not sure you get a very good idea of what the population looks like from this segment.

Well, you made it to the end of my "brief" and poignant remarks. Seriously, I hope this has helped and it's been an honor to even be asked my opinion. The questions asked were good ones (except #1) and unfortunately the answers are complicated and multi-determined. I'll be glad to expand ad nauseum should the need arise. Good luck.

Sincerely,
A. Thomas McLellan
A. Thomas McLellan
215-823-5809

QUESTIONS AND RESPONSES OF WILLIAM R. MILLER, Ph.D, TO WRITTEN QUESTIONS SUBMITTED BY SENATOR GLENN

1. Would you agree with the statement of Dr. McElrath that the Hazelden Program is the most successful treatment program in recorded history?

2. In your opinion, is the reason that people have an unsatisfactory response to treatment a result of their having failed to comply with the treatment conditions, had an inappropriate treatment given to them, or some combination of the two?

3. Health insurance providers, as well as Medicare/Medicaid, preferentially reimburse clients for hospital-based or residential alcoholism treatment. Your testimony would seem to suggest that the "best" treatment is often to be found in less intensive, non-residential settings. What are your recommendations to this Committee in shifting the emphasis of Medicare/Medicaid and third-party providers away from hospital-based treatment to less intensive, non-residential treatment settings?

4. How important is aftercare in the maintenance of sobriety once a person has been detoxified in primary treatment?

5. Why do you think there has been so little research in the United States on the value of behavioral self-control training in alcohol abuse treatment when it is the model for treatment in Europe?

6. Do you believe that abstinence as a treatment outcome goal is appropriate for all problem drinkers? If not, what categories of clients should have abstinence as a goal and what types of clients may be re-educated to non-problem drinking?

7. For any of the treatment components or strategies you discussed at the hearing, which strategies, in your opinion, are the most effective for prolonged periods of non-problem drinking?

8. A witness to one of our earlier alcoholism hearings recommended that NIAAA allocate increased funding for data collection, prevention and psychosocial research, and the establishment of a national research center on Women, Alcohol, and Other Drugs. How do you feel about this suggestion?

9. It has been suggested that the Federal Government maintain a mandatory data base on clients that use publically funded alcohol abuse treatment services. Do you feel that such data collection activities ought to be re-established as a formal, Federal mandate or should the data collection activities remain as they are?

10. What explanation do you have for the apparent gap in information transfer between the alcohol abuse treatment research community and alcohol abuse treatment centers? What suggestions could you make to bridge this gap?

Responses to specific inquiries from Senator Glenn (23 June 1988)
William R. Miller, Ph.D., University of New Mexico (7 July 1988)

1. I know of no scientific evidence to substantiate Dr. McElrath's surprising claim that the Hazelden model "is the most successful form of treatment in recorded history." The recent report of Hazelden outcomes (Gilmore, Jones, & Tamble, 1986) is based on questionnaires mailed to former patients. They excluded from their analyses any patients who did not complete treatment, who had died, or who failed to return the questionnaire. Of the remaining sample, 73% said they were abstinent (51% of the original sample) at 6 months. The report indicates that significant others were interviewed to verify self-report, but the procedures are not specified, no corroborating data are provided, and it is not stated how many such interviews were conducted. These are, to my knowledge, the strongest data regarding Hazelden's outcomes.

The shortcomings of such methodology are obvious. Excluding deceased, uncooperative, and lost cases inflates one's success rate. Knowledge of outcomes relies upon questionnaire self-report, which is not adequately verified by more objective measures. Still more seriously, one does not know with what to compare the resulting success rates. The Hazelden model has never been subjected to a properly controlled clinical trial, and the remission rates could be attributable in large part to favorable prognostic characteristics of a population who can afford to go to Hazelden, cooperate with treatment, are discharged with approval of staff, survive to follow-up, and return their questionnaires. Dr. McElrath's statement implies a comparison of Hazelden with other treatment approaches, and asserts that Hazelden is superior to other forms of alcoholism treatment. To my knowledge, Hazelden's treatment has never been adequately tested against other treatments or controls.

Even if one compares the Hazelden data to similarly collected results from other treatment programs, it is not apparent that Hazelden has dramatically better success. The outcome data of the Schick hospitals, for example, have been published in refereed scientific journals since the 1940's, and their rates of successful outcome appear to be at least comparable to if not better than those reported by Hazelden. Such comparisons are, of course, risky in any event, because treated populations may differ dramatically in pretreatment characteristics and posttreatment environment.

Finally, if one examines the typical content of Hazelden model programs, it resembles the list of components which I enumerated in my own testimony as commonly used but scientifically unverified. The Hazelden programs, to my knowledge, incorporate few if any of the specific treatment modalities that I listed as having received reasonable scientific evidence for effectiveness. This would lead one to question whether a program constituted of elements which are of dubious or unknown effectiveness would be superior overall to other approaches.

In sum, I found Dr. McElrath's statement to be an irresponsible claim unsubstantiated by current scientific evidence.

2. The reasons for treatment failure are complex, and certainly include the two that you specify. Current research on matching indicates that untoward outcomes can result in alcoholism (as in medical conditions) by giving the patient the wrong treatment. Thus one reason for failure can be an inappropriate treatment assignment, or the delivery of types of treatment which are generally ineffective.

The second reason you specify, patient compliance, is also significant. There is a rather clear relationship in the literature between patient motivation/compliance and favorable outcome. This appears to be true regardless of the type of treatment offered. High compliance with a placebo medication, for example, is associated with a high recovery rate among alcoholics. This suggests at least two possibilities. First, patient traits ("low motivation") may be predictive of outcome regardless of treatment. Secondly, any aspect of treatment which increases client motivation and compliance is likely to increase success rate. As I read the literature, I lean toward the latter as a more powerful determinant of outcome. In any event, compliance is important.

Other patient characteristics may be determinants of outcome. For example, no treatment (to my knowledge) has been very effective for alcoholics with antisocial personalities. Specific personality traits seem to mark responsiveness to particular treatments, again pointing to a need for matching.

The most powerful determinants of outcome, however, are neither personality nor treatment characteristics, but rather the environment and experiences of the patient _after_ treatment. Regardless of the treatment received, a patient who is unemployed and homeless is unlikely to remain sober. Family stability, social support, work stability, and drinking patterns of peers are important influences. We tend to overestimate the power of the treatment phase, while overlooking the environment to which we are discharging patients. It is no coincidence that the list of scientifically-substantiated treatment methods includes quite a few which are directed at altering the patient's posttreatment environment and relationships.

3. The treatment reimbursement system in the U.S. does indeed place undue emphasis on the most expensive forms of treatment. This was the substance of the Office of Technology Assessment report commissioned by the Congress and published in 1983. The incentives for sustaining a system of this kind are obviously economic. Alcoholism treatment is big business, and one of the few money-makers in a health care market where profits are increasingly constrained by the DRG system.

Health care delivery in the U.S. is powerfully influenced by economic factors. Thus the policies that govern Medicare/Medicaid and third party payment are important determinants of how services will be provided. As I understand current reimbursement policies, there are substantial incentives to overuse hospital treatment for alcoholism. The primary beneficiaries of such policies are for-profit providers, and perhaps the insurance systems. Within HMOs and PPOs, the incentives are dramatically different, and favor minimal use of hospitalization (similar to the European system).

At a minimum, I would recommend considering alterations in reimbursement policy toward several goals:

1. Ensure that reimbursement policies do not differentially favor the use of more expensive (e.g., inpatient) treatment settings. It should not cost the patient more to receive outpatient treatment than to enter a hospital. Current policies often provide more favorable coverage for hospital-based treatment, with the net effect that the patient is financially penalized for using treatment settings which are, overall, less expensive.

2. Build in provisions that favor an adequate trial with less expensive treatment forms and settings before more heroic treatments are tried. Except where there are pressing additional reasons for hospitalization (e.g., acutely suicidal), less intensive and nonresidential alternatives should be tried first. (It has not yet been shown by research, incidentally, that hospitals do work when outpatient treatment fails. That remains an open question.) Competent nonresidential treatment should be a pre-approval condition for residential treatment, except where emergency conditions warrant immediate hospitalization.

3. Intensive and residential treatment should continue to be made available for those who genuinely need such services. Best available information suggests that this will be the indigent, homeless, and severely addicted. By implication, those who genuinely need residential care will be unable to pay for it themselves. Thus changes in reimbursement policy should not make residential care less accessible to those who need but cannot afford it.

4. In general, by whatever economic incentives are available, encourage the development of less costly but effective treatment systems. Private hospitals are likely to serve populations least in need of residential care - the employed, socially stable, and generally less severe individuals. EAPs similarly have overemphasized residential treatment for employed populations likely to do just as well in less intensive settings. Incentives are needed to consider and utilize less costly options.

4. The term "aftercare" implies that the individual has completed an intensive (usually residential) phase of treatment and now needs additional care afterwards. What aftercare consists of, in fact, is outpatient treatment and/or participation in support groups such as A.A.

Current data indicate that aftercare participation is associated with successful sobriety. This may, however, just be a special case of the overall principle that treatment compliance is a marker of success. Another possibility is that aftercare *is* the treatment! In any event, relapse following residential treatment is high without some form of treatment or support that carries forward into the patient's natural environment. Again, the posttreatment environment seems to be a more powerful determinant of sobriety than treatment itself. The current strong emphasis on "aftercare" is, in my view, part of the overemphasis on residential treatment.

If your question is directed specifically at *detoxification*, then the answer certainly is yes. Detoxification alone cannot be expected to induce a change in drinking problems. Although detoxification is an important medical service, it is not treatment. The "revolving door" aspects of detoxification services are well known. Detoxification services should be linked with specific interventions designed to increase motivation for change and to match individuals with optimal treatment strategies.

5. Treatment in the U.S. has underemphasized not only self-control training, but virtually all of the treatment components on the list of those for which there is reasonable scientific evidence of effectiveness. Self-control training is merely a special case of a more general ignoring of alternative effective treatment modalities. Treatment in the U.S. is overwhelmingly dominated by a single ideology rooted in Alcoholics Anonymous and manifested in the "Minnesota model" programs. This is an appropriate form of treatment for some alcoholics. The problem has been the exclusive promulgation of this model as the only successful and acceptable approach (or, more recently, as the "most successful in recorded history.")

The reasons for this hegemony are a matter of speculation. It is a phenomenon restricted almost totally to the United States. It is related, certainly, to the remarkable acceptance of Alcoholics Anonymous in this country. But why is this model so attractive to Americans?

I believe that the central attraction is the attribution of alcoholism to biological factors beyond the individual's control. The common assertion is that alcoholics are constitutionally different from normal people - that they were born that way. This view is appealing to many major groups: (1) It is appealing to alcoholics, because it relieves them of responsibility for the etiology of their condition and, perhaps, for their behavior during it. (2) It is appealing to the medical treatment industry because it qualifies alcoholism as a medical illness requiring the ministrations of health professionals. (3) It is strongly supported by the alcohol industry because it exonerates alcohol of involvement in the problem. Alcoholism is not caused by alcohol within this model (an absurb assertion in other countries). Rather it is the fault of some genetic flaw for which alcohol manufacturers bear no responsibility. (4) Finally, it is appealing to all those who regard themselves to be nonalcoholics, because they can drink with impunity. Only alcoholics are at risk.

Another important factor has to do with the unique history of alcoholism treatment in the United States. Until the 1960's, alcoholism was not taken seriously by health professionals. A.A. was one of the only sources of support and help. As treatment centers evolved, they were staffed by recovering alcoholics without professional training, on the belief that alcoholics are best understood and treated by one of their own kind. Professionals entered the treatment picture relatively late in the game, after a paraprofessional/A.A. system was already in place. Thus the very kinds of scientific questions that you are asking are only recently receiving attention. Standards of scientific evidence for effectiveness of treatment are only now starting to be considered in alcoholism treatment. The predominance of paraprofessional treatment personnel, without professional training and committed to a particular ideology, has been an important shaping force in our treatment system. To such individuals, consideration of alternative models and professional or scientific standards may be personally threatening. In addition, the American-disease model has now been ossified into a for-profit treatment delivery system which has substantial economic investment in this approach. Efforts to introduce treatment innovations are met with strong resistance from these interests.

6. I am quite clear that neither abstinence nor moderation is an appropriate goal for all problem drinkers. Both goals are appropriate to consider, and each is best for certain individuals.

Realize first that alcohol problems are not discontinuous. They are not the sole possession of a small minority of people who are qualitatively different from normality. Rather they occur to varying degrees throughout the population, and increase on a continuum. At one end of the continuum are "normal" drinkers for whom alcohol poses few or no problems. Unless one wishes to return to prohibition, total abstention is not a goal for these people. At the other end of the continuum are severely addicted, socially unstable alcoholics who may have multiple alcohol-related offenses, liver disease, and neuropsychological impairment. Almost no one proposes a moderation goal for such individuals; abstinence is clearly the goal of choice. In between is a great range of individuals with varying degrees and types of alcohol-related problems. Some choose abstinence and succeed with it. Some choose moderation, cut down their drinking, and no longer show problems related to alcohol. Both are successes.

An interesting question is how these two groups of successes differ from each other. Although the data are not wholly consistent, at least the U.S. studies present a fairly clear picture. Those who succeed at problem-free moderation differ from successful abstainers by: (1) drinking less to begin with, (2) having less severe alcohol problems and dependence, and (3) rejecting a self-label of "alcoholic" and a goal of abstinence. Several studies find that women are more successful than men at moderation. We also found a relationship between abstinence and higher family history of alcoholism. The overall picture: The more severe the person's alcohol problems, the more likely it is that abstinence will be the outcome. The less severe the problem, the more likely it is that moderation will be the outcome. I have sent along several papers on this subject, with additional research details.

Given this overall picture, however, it is sensible that the main use of moderation-oriented training procedures would not be in detoxification centers, but rather in secondary prevention settings where problem drinkers are identified early in their development process. Examples would be employee assistance programs (EAPs), primary health care settings, emergency rooms, colleges and universities (e.g., fraternities, counseling centers).

The clinical procedure that we use is to screen candidates for conditions that would clearly contraindicate a moderation goal. Examples include pregnancy, liver disease, idiosyncratic intoxication syndrome, court mandate to abstinence, and severe addiction. If such signs are not present and if the individual prefers a moderation goal, we try self-control training. If it fails, we then counsel the person toward abstinence. Thus, in a sense, this approach is diagnostic, identifying people for whom moderation is not feasible. We found that anybody who succeeded in moderation in the long run had shown clear progress in the early months of treatment. In addition, a failure at moderation treatment tends to increase the person's openness and motivation to consider abstinence.

7. Which treatments are most effective for prolonged periods of non-problem drinking? I understand this to be a question about what approaches are most effective in helping clients to sustain moderate and problem-free consumption over long spans of time.

There are, thus far, two kinds of interventions which have been shown to be followed by long spans of problem-free alcohol consumption. One is behavioral self-control training (see enclosed chapter). This has been offered in many different forms and settings, and has been tested in at least nine different countries. The results have been rather consistent, and include individuals showing prolonged periods without alcohol problems.

The other is what I discussed as "brief intervention." There is, again, some consistency to the content of brief interventions which have been tested in several different nations. I have tried to capture this in the acronym FRAMES: giving Feedback of personal impairment, counseling personal Responsibility for making a change, giving clear and specific Advice to change drinking pattern, providing a Menu of options by which one might change one's drinking pattern, showing personal Empathy in a client-centered (rather than confrontational and directive) style, and encouraging Self-efficacy - the optimism that one can succeed in changing one's drinking. This type of intervention is particularly applicable in health care settings.

By far, however, the largest number of people who moderate their drinking do so on their own without formal aid, "spontaneously." Such change is not actually spontaneous, but occurs in response to a variety of experiences and changes in people's lives. It would be fascinating to understand better what factors precipitate such changes outside of treatment settings.

Finally, I would say that we are at relatively early stages in our understanding of which procedures best promote moderation. Research on this subject has ground to a virtual halt in the United States because of intense political pressure against "controlled drinking." Happily, such research is proceeding apace in other countries where prevention is emphasized more heavily.

8. I do not know the specifics of what the previous witness recommended for future NIAAA funding. Labels such as "prevention" can cover a host of merits or sins. Here are my thoughts on future directions for NIAAA funding.

First, on data collection and research: I concur fully with Dr. McLellan that what is needed is a somewhat higher level of funding for treatment research, but more importantly a steady, reliable, and moderate level of research funding. Having done treatment research for 15 years, I am increasingly aware that very little can be learned in programs of 1-2 years. Sustained and reliable funding permits agencies like NIAAA to support the kind of programmatic efforts that yield real fruit. I would urge the Congress to avoid tidal waves of money, such as has occurred in the recent "war on drugs." In my opinion, most such funds are wasted because in a one-time rush to fund, inadequate preparation and planning occur. The funds must be expended within a fixed time, and there is pressure to fund unworthy projects. Quality-control is absolutely vital in research funding. I believe that the present NIAAA structures do this very well.

Secondly, I favor steady, reliable, moderate funding for prevention research. The current level of funding could certainly be increased with good results. I specifically do not recommend a major increase in funding for prevention programming at the present time. The fact is that we have almost no idea how to prevent alcohol and drug problems, and major funding for programming would set off even more implementation of untested interventions. I am distressed that entire school districts now being exposed to "prevention" programs for which we have no adequate scientific evidence of effectiveness. Some such "prevention" programs in schools have actually been shown to increase drug involvement of students. I would favor a mandatory stipulation that any federally-funded prevention program must have a very solid scientific evaluation component reviewed and approved through the usual research review channels. This is not to restrain innovation, but rather to ensure that when innovation occurs we will have some sound evidence of its impact. This is particularly crucial in prevention programs, where whole populations are exposed to risk.

Thirdly, I honestly believe that current research priorities massively overemphasize biomedical investigation. Under the current administration, support for psychosocial research has diminished dramatically, and there has been a full court press to find the biological causes of disorders. We are inundated with studies of the impact of alcohol on cell membranes, neurotransmitters, the liver, enzymes, and other physiological systems. These are worthy topics for investigation, but not at the expense of research on prevention, treatment, and psychosocial determinants of alcohol abuse. This overemphasis on biological variables is consistent with the view, discussed in question 5, that alcoholism is a biological aberration, and that we must find the gene or enzyme that makes alcoholics qualitatively different from normality - "the quest for the test." This is, from my perspective, a fundamentally flawed undertanding of the nature of alcohol problems. I would reference here the excellent 1981 report from the National Academy of Sciences, "Alcohol and Public Policy: Beyond the Shadow of Prohibition," as well as Dr. Don Cahalan's superb analysis in his 1987 book, "Understanding America's Drinking Problem."

Regarding the establishment of a separate national research center on Women, Alcohol and Other Drugs, I am not enthusiastic. You must, of course, consider the fact that I am a male, and my views are necessarily colored by this. Nevertheless, my personal view is that a separate institute is not warranted. Unquestionably we need more research on women's alcohol problems and their prevention and treatment. I believe that the appropriate mechanisms for encouraging such research are RFPs through existing review channels at NIAAA. I do not believe that the creation of a separate beaurocracy is either necessary or desirable.

Finally, I would point out that the Institute of Medicine of the National Academy of Sciences is currently completing a report to Congress with specific recommendations on opportunities for research on the prevention and treatment of alcohol problems. This report will contain the collective and consensus wisdom of two panels of experts on this subject, and should be given greater weight than the personal opinions of any individual, including myself.

9. It is not unreasonable that the federal government should require a standard data base from programs receiving federal funding for the treatment of individuals with alcohol problems. The absence of standardized measures has been a major problem in this field, and a well planned standard assessment could advance our knowledge of treatment outcomes.

The key here is "well planned." If there is a return to a standard data base, I would encourage a redesigning of earlier systems. There have been substantial advances in assessment over the past decade, and a small panel of experts at this point should be able to assemble a much better system.

The other provision that I would encourage is funding for the hiring, at each federally-funded treatment site, of a research professional whose task is to implement not only the federal assessment system, but also on-site program evaluation research. This is consistent with the direction in which JCAH is moving. My recommendation is based on my own experience that research simply never gets time or priority within treatment systems unless there is a person whose job it is to do it. A training program could be designed by NIAAA to prepare such individuals to implement the federal assessment system and to conduct program evaluation research.

Given these provisions, I would favor a return to standardized assessment within federal sites (including VAMCs).

10. I have written and am enclosing a paper which specifically addresses this question of why there is such an enormous gap in information transfer. My paper analyzes the question from two sides: shortcomings in the potential recipients of such information (i.e., the providers), and shortcomings in those who generate the information (i.e., the researchers). The paper includes some specific recommendations on how to bridge this gap. I will comment only briefly here.

One major problem has been a lack of connection between researchers and the channels through which information is typically communicated to practitioners. We researchers seldom write for practitioner periodicals. Instead we publish our work in technical research journals and are then offended that it is not applied. Mechanisms are needed for the "marketing" of research knowledge. These could include: (1) increased publication by researchers in practitioner language and periodicals; (2) more practitioner-oriented translations of new research knowledge to be disseminated by NIAAA; (3) requirement for and funding of dissemination strategies as a part of any treatment research grant.

The other side of the picture, however, is the incestual nature of the current professional community. There are hundreds of meetings and conferences for practitioners in alcohol and drug abuse, most of which consist of research-unsubstantiated rehashing of the dominant dogma. The rapidly growing system for accrediting Certified Alcoholism Counselors is based, in part, on the applicant's knowledge and endorsement of traditional dogma - nearly a statement of faith in the American disease model. If mechanisms could be devised for tying certification and continuing education to research dissemination instead of dogma rehearsal, substantial gains could be made. The requirements for certification are largely under the control of state legislatures at present. Continuing education could be at least modestly impacted by large federally-sponsored conferences designed for practitioners, featuring updates on research knowledge.

The factor that, I believe, is making the most difference in reducing the gap, however, is the gradual professionalization of the field. We have come a long way from treatment delivery by largely untrained recovering paraprofessionals. What may be most crucial is federal influence over what kinds of professionals can be reimbursed for providing alcoholism treatment. If reimbursement is tied to professions where reasonable scientific training and appreciation for research is normative, advancement will continue. If treatment delivery reimbursement is liberalized to include providers detached from research dissemination, the gap will widen. Federally accessible mechanisms here would include: (1) increased support for training of health professionals in alcohol abuse and its treatment; (2) encouragement of research-based content in certification programs; (3) support for JCAH trends toward requiring evaluation research as a component of accredited treatment facilities; and (4) great restraint in broadening the base of reimbursable providers to groups where science-based training is not normative.

THE EFFECTIVENESS OF ALCOHOLISM TREATMENT MODALITIES

Testimony to the U. S. Senate Committee on Governmental Affairs

Dr. William R. Miller

16 June 1988

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INTRODUCTION

I am Dr. William Miller from the University of New Mexico. I am Professor of Psychology and Psychiatry, and Director of our doctoral training program in clinical psychology. Alcoholism treatment is my primary research area. I am not affiliated with any particular treatment program, and I have been studying the effectiveness of a variety of treatment alternatives over the past 15 years. I am currently serving as the principal investigator for four federally-funded grants to study alcoholism interventions. I have been a consultant to the National Institute on Alcohol Abuse and Alcoholism and to the National Institute on Drug Abuse. Presently I am serving on two alcoholism treatment panels for the Institute of Medicine of the National Academy of Sciences. I am honored by the invitation to speak to your Committee, and I will be glad to provide whatever information may be helpful to you in your deliberations.

You have asked me to speak to a number of complex issues including: (1) What is known from research about the effectiveness of various treatment modalities for alcoholism; (2) Whether a gap exists between approaches currently used by practitioners in the field and those employed in treatment and research endeavors funded by the federal government; (3) How treatment setting influences outcome; (4) How individuals are best matched to treatment modalities; (5) What impact brief interventions have on reducing alcohol abuse among susceptible populations; and finally (6) How alcoholism treatment in the United States compares with treatment approaches employed in other countries.

I will endeavor to provide you with the absolute "bottom line" conclusions that can be drawn from current research in these areas. Please understand that there are now more than 600 published studies of the effectiveness of various approaches for treating alcohol problems. I have been reading and writing reviews of this literature for the past ten years. These are very complex issues. I have provided your staff with detailed research documentation of the conclusions that I will summarize here for you.

THE EFFECTIVENESS OF ALCOHOLISM TREATMENT MODALITIES

1. First, it can be said with some confidence that we now have available to us a variety of effective treatment modalities. Several specific methods have been shown in well-controlled scientific research to yield significantly better outcome than no treatment or alternative treatment approaches. This should not, however, be taken as a blanket endorsement of the effectiveness of all alcoholism treatment programs.

2. There is no one outstandingly effective treatment. No one approach has been shown to be far better than all others. The grounds for optimism regarding alcoholism treatment are not to be found in a single superior approach, but rather in the range of promising alternatives now available.

3. All treatments are not equal. There are significant differences among treatment modalities with regard to outcome, based on presently available research data. Table 1 provides a summary of findings from current well-controlled treatment studies.

Table 1

SUMMARY OF EVIDENCE FROM CONTROLLED CLINICAL OUTCOME STUDIES[1] OF ALTERNATIVE ALCOHOLISM TREATMENT MODALITIES

	Positive[2] Studies	Negative[3] Studies	Percent Positive
TREATMENT METHODS SHOWN TO BE EFFECTIVE[4] IN FEDERALLY-FUNDED AND OTHER RESEARCH			
Brief Advice/Feedback Intervention	7	0	100%
Community Reinforcement Approach	4	0	100%
Covert Sensitization	4	3	57%
Disulfiram (Antabuse)			
Monitored (including implants)	4	4	50%
Marital Therapy (Behavioral)	7	0	100%
Self-control Training	9	7	56%
Social Skills Training	10	0	100%
Stress Management Training	7	3	70%
TREATMENT COMPONENTS COMMONLY USED (U.S.)			
Alcoholics Anonymous	0	3	0%
Confrontational Counseling	0	3	0%
Counseling (General)	0	3	0%
Disulfiram (Antabuse) - not monitored	2	3	40%
Educational Lectures/Films	2	4	33%
Group Psychotherapy	2	11	15%
Individual Psychotherapy (Insight)	0	7	0%
OTHER TREATMENT MODALITIES			
Acupuncture	1	0	100%
Aversion Therapy (Nausea Induction)	1	4	20%
Aversion Therapy (Electric Shock)	5	9	36%
Cognitive Therapy/Relapse Prevention	3	4	43%
Hypnosis	2	2	50%
Marital Therapy (Nonbehavioral)	1	1	50%
Psychotropic Medication			
Anti-anxiety	1	5	17%
Antidepressants	3	1	75%
Antipsychotic	0	2	0%
Lithium	2	5	29%
Psychedelic	2	7	22%
Videotape Self-confrontation	0	5	0%

Notes:

1. Table includes only controlled studies (i.e., those comparing a specific treatment with no treatment, minimal or alternative treatment). The intent is to include all studies which could reasonably be called "controlled." Methodological rigor varies widely among these studies.
2. Positive study = better outcome than no treatment, minimal treatment, or alternative treatment
3. Negative study = no better outcome than no treatment, minimal treatment, or alternative treatment of similar intensity
4. "Shown to be effective" = at least 4 positive studies, and available studies are at least 50% positive

I would add here that about 80% of the studies reported in Table 1 were conducted within the United States, and many of these were supported by federal grants. This table thus summarizes the current state of research knowledge that has emerged from federally-funded controlled outcome studies of alternative treatment modalities.

THE FEDERAL/PRACTICE GAP

An examination of Table 1 suggests that there is a substantial gap between available research knowledge (much of which has emerged from federally-funded studies) and current practice. The treatment modalities listed as "shown to be effective" by current research are, on the whole, rarely used in current U.S. practice. The community reinforcement approach, which has yielded some of the strongest treatment effects in the alcoholism research literature, has had little application beyond the original governmentally-supported studies. Social skills training, which also has a strong record, has been used (within the U.S.) mostly in Veterans Administration hospitals and research programs. Stress management training likewise is not a common element of treatment. The form of stress management that _is_ used with some frequency - relaxation training (sometimes administered by having patients listen to tapes) - is the one form that has yielded negative studies, and appears to be of limited usefulness without further application training. Covert sensitization is rarely employed, having been applied mostly in V.A. and research settings. Family interventions, though now commonly used, seldom employ the empirically-tested behavioral approach and are largely based on strategies of unknown effectiveness. Self-control training is routinely shunned and rarely used in the United States, though it is a common approach in other countries. When disulfiram (Antabuse) is prescribed in routine alcoholism treatment, it is seldom accompanied by a systematic compliance program, which appears to be crucial to its effectiveness. The mere prescription of this drug, without monitoring and compliance assurance, has a very limited impact.

Although it is difficult to describe a "typical" treatment program, standard practice in U.S. programs commonly includes the components listed in the second section of Table 1. What is striking is that none of these components has thus far been demonstrated (in properly controlled studies) to have a specific beneficial impact on alcohol problems. That is, traditional U.S. alcoholism programs are based on treatment methods that are largely unsupported by current research evidence. In contrast, treatment modalities that appear promising from current scientific evidence are mostly unknown or unused outside of federal V.A. or research-supported programs.

THE IMPACT OF TREATMENT SETTINGS

Is alcoholism treatment best conducted in a hospital setting? This question has now been addressed in 20 controlled studies. In the typical study, alcoholics who would otherwise have been eligible for inpatient admission were assigned at random to be treated in residential versus nonresidential settings. Other studies have compared the effectiveness of longer versus shorter residential stays, again with random assignment. The findings of these studies have been strikingly consistent. Of 20 studies, 19 found no overall advantage for residential over nonresidential treatment, or for longer versus shorter residential stays. That is, all else being equal, the success rate of a treatment program does not appear to be increased by making it longer or offering it within a residential setting.

This is consistent with the conclusions of virtually every expert panel that has reviewed this issue. The World Health Organizations's Expert Committee on Alcoholism concluded in 1951 that the treatment of alcoholism would seldom necessitate hospitalization. In a congressionally-mandated study, the Office of Technology Assessment determined in 1983 that resources were being inappropriately focused on needlessly expensive approaches to alcoholism treatment, where less costly (and hence more cost-effective) alternatives could be equally efficacious.

PERSON-TREATMENT MATCHING

Given that no single treatment approach appears to be superior across the board for all people with alcohol problems, are specific approaches more effective for certain _types_ of people? This raises the question of how to match individuals with optimal treatment strategies, an issue to which the National Institute on Alcohol Abuse and Alcoholism has recently given high priority for future research.

It does indeed appear to be true that certain treatment modalities (and perhaps settings) are most effective for certain types of people. Imagine two treatments (A and B) and two kinds of people with alcohol problems - perhaps those who are severely addicted to alcohol and those who are not. For one type (the addicted), Treatment A is significantly more effective than Treatment B. Yet for the other (nonaddicted) kind of person, the opposite is true: Treatment B is better than Treatment A. Realize also that if all kinds of people are mixed together, the two treatments may be judged (incorrectly) to be no different from each other in effectiveness. This has been found to be the case in several studies, and more research of this kind is needed.

This means that the question, "Which treatment is best for alcoholism?" is far too simplistic. First of all, there is no single superior treatment approach. Beyond this, however, a better and more complex question is, "Which treatments are best for which kinds of people, in which treatment settings?"

This has some important implications for state-of-the-art treatment. Treatment systems should not offer a unitary program to all who seek their services. No single treatment approach will be effective in the long run for all (or even most) individuals. Rather, given the state of our research knowledge, it is appropriate to have available a range of different treatment strategies, each of which will be optimal with certain types of individuals and problems. This is, in fact, the state of the art in the treatment of many complex health problems such as hypertension, cancer, depression, and heart disease. No single modality is appropriate for all cases, and treatment is conducted by selecting an appropriate combination of strategies from among those methods which have been shown by research to be of potential benefit.

Treatment, thus, should be tailored to the needs of individuals. More knowledge is needed regarding how best to do this. One reasonable strategy, often used in medicine, is to start with simpler, less intrusive, and more cost-effective strategies. If these are insufficient, more intensive alternatives can be tried. It is also reasonable to involve the individual in choosing his or her own treatment strategies, given an informed consent of the available alternatives and their known effectiveness.

An example of the importance of matching is found in the issue of treatment settings, previously discussed. Although residential and nonresidential treatment settings are equivalent overall with unselected patients, it is possible that for certain types of people one setting would be more effective than another. The available research evidence contains some indication that this may be so. A more intensive, residential approach appears to be most effective with people who are more deteriorated - those with more severe alcohol problems and addiction, and who are socially unstable (e.g., have no family and no stable residence). Those with less severe problems and more intact social resources, in contrast, appear to be at least as likely to benefit from less intensive outpatient approaches. Ironically, those who can afford to pay for their own residential treatment may be least likely to need it. If this finding holds up in future research, it supports the need for publicly-funded facilities to provide treatment for those who need but cannot afford residential care.

BRIEF INTERVENTION

Research over the past 20 years has pointed to the effectiveness of certain brief intervention approaches for reducing alcohol problems. Studies from the United States, Scotland, England, New Zealand, Sweden, and Norway have indicated that specific brief interventions are more effective than no treatment, and are sometimes comparable in overall impact to more extensive treatment. The content of these effective brief interventions has been interestingly consistent across this wide range of national settings. It appears that relatively brief (1-3 contacts) intervention can significantly decrease the incidence and severity of future alcohol problems and related health care costs, particularly with problem drinkers who have not yet become substantially dependent upon alcohol.

These findings suggest that we, in the United States, have been far too narrow in focusing on the formal treatment of more severe forms of alcoholism. Our intervention efforts could be improved first by addressing the full spectrum of alcohol-related impairment and problems, rather than focusing on a narrow diagnostic range of alcoholism. This was a central implication of a report published by the National Academy of Sciences (Moore

& Gerstein, 1981). Secondly, greater emphasis should be given to early intervention, before the development of severe impairment and problems. Thirdly, intervention should be expanded well beyond formal alcoholism treatment settings in order to reach more at-risk individuals. Brief interventions can be offered in a wide variety of settings including emergency rooms, routine medical care settings, employee assistance programs, educational institutions, and community programs for offenders. By offering brief interventions in a better array of settings, it is possible to reach a broader range of people at earlier stages in the development of alcohol-related health and social problems.

CONTRASTS WITH APPROACHES IN OTHER NATIONS

In addressing this issue of cross-national comparisons, I must first acknowledge the limited breadth of my experience. I have been a frequent visitor to Canadian alcoholism treatment programs, having consulted in Ontario, Manitoba, Alberta, and British Columbia. I lived for six months in western Norway and worked in inpatient and outpatient alcoholism services there. I have visited alcoholism treatment programs in the Soviet Union, Sweden, Denmark, Germany, England, and Scotland. I correspond regularly with alcoholism treatment professionals from other nations. My experience, however, is primarily based on programs in North America and Europe. I do not profess knowledge of programming in Africa, Asia, or Central and South America. Thus I can best contrast U.S. alcoholism treatment with the comparable service delivery systems in Canada and Europe.

The most obvious contrast, of course, is that our health care system is substantially privatized, whereas alcoholism treatment services in Canada and Europe are provided almost exclusively through publicly-funded agencies. This introduces a significant profit motive into our treatment system which is much less prevalent in other nations. Considerations of cost-effectiveness have been stronger in Canada and Europe, where the burden of payment for treating alcohol problems is borne by all taxpayers.

Considering this fact, it is understandable that much greater emphasis has been given outside the United States to nonresidential treatment settings. Hospital-based treatment of alcoholism has been deemphasized, and is used primarily with the most severe and socially unstable cases who are unresponsive to less intensive alternatives. For-profit treatment centers are present in most countries, but serve a very small proportion of their populations.

Greater priority is likewise given to early preventive interventions in other countries. Programs for early identification and brief intervention have been employed in the health care systems of Canada, Britain, France, Scandinavia, and Australia. Findings of a well-controlled Swedish study demonstrate a significant decrease in health-care utilization and alcohol-related diseases among problem drinkers over 5 years after brief intervention. The World Health Organization is currently conducting a major cross-national collaborative study of the effectiveness of brief preventive interventions with problem drinkers.

Relatedly, other nations place considerably less emphasis on the disease entity "alcoholism," and instead focus their education and intervention programs on the broader range of alcohol-related problems. U.S. efforts have operated most often from a dichotomous notion of alcoholism - that either one has it or does not have it. A public assumption underlying this U.S. view is that if one has alcoholism, one cannot drink; whereas if one does not have alcoholism, there is no great reason for concern about drinking. Other nations recognize that alcohol problems exist along a continuum, and tend not to draw sharp lines between "alcoholics" and "nonalcoholics." Their prevention and intervention programs are guided by this continuum model. The concept of safe limits for drinking is strongly emphasized in many European nations. The reduction of alcohol consumption to conform with safe limits is a common emphasis in European health care.

Treatment modalities with a documented track record of success have been utilized to a greater extent outside than inside the United States, even though the research substantiating their effectiveness is largely American. Aversion therapies are a routine component of most Soviet alcoholism treatment programs. Stress management is widely used in British alcohol programs. European programs in general make greater use of psychotropic medications, particularly antidepressants, whereas many U.S. programs shun these as part of a total "drug-free" emphasis, even in cases where they are appropriate for the treatment of concomitant clinical depression. Self-control training is nearly heresy in the U.S., but is standard practice in many British, Scandinavian, and Canadian treatment systems. Public health programs in Britain, France, and Australia have employed self-control training principles toward the prevention of alcohol problems in the general population. Overall, the treatment systems of Canada and Europe impress me as offering a broader range of treatment options, appropriate to the spectrum of severity and types of alcohol problems. The typical American program - based on an Alcoholics Anonymous disease model, featuring confrontational counseling, and relying heavily upon recovering counselors as therapeutic agents - is a relatively rare approach in most other nations.

SUMMARY OF CONCLUSIONS

1. A number of alternative approaches have been found to be effective in the treatment of alcohol problems. Reasonable scientific evidence has emerged to support the efficacy of the community reinforcement approach, covert sensitization, monitored disulfiram, behavioral marital therapy, self-control training, social skills training, and stress management training. Unfortunately, these approaches are rarely implemented in the United States outside of federally-supported research and V.A. treatment settings.

2. Standard practice in nonfederal alcoholism treatment programs typically consists of a combination of Alcoholics Anonymous, confrontational and other counseling, group psychotherapy, educational lectures and films, and unmonitored disulfiram. None of these components has been proven by properly controlled research to be an effective treatment for alcohol problems. A substantial gap exists between current practice and the knowledge gained from federally-funded research.

3. Residential treatment settings yield no higher overall rates of successful outcome than less expensive nonresidential treatment alternatives. Longer residential programs likewise have not been shown to be more effective than shorter programs. The outcome of treatment appears to be impacted more by the content of treatment than by the setting in which it is provided. Residential care may be more effective for severely addicted and socially deteriorated individuals.

4. There is no single superior treatment approach for alcohol problems. The "best" treatment varies with characteristics of the individual. An optimal treatment system offers a variety of alternative approaches, individualizing treatment plans and selecting intervention components appropriate to the needs of each person.

5. Specific and relatively brief (1-3 session) interventions have been shown to reduce long-term alcohol consumption and related problems. Such interventions are highly cost-effective, and can be offered in a broad range of settings beyond traditional alcohol treatment systems. Well-planned brief interventions may be comparable in impact to more extensive treatment programs, at least for persons with less severe alcohol problems. A graduated approach to intervention is logical, starting with less expensive and intrusive approaches and advancing to more intensive strategies until a successful outcome is achieved.

6. U.S. alcoholism treatment systems differ substantially from those currently used in other nations. U.S. programs have relied more heavily on hospital-based treatment despite evidence that it is less cost-effective. Preventive, early, and brief interventions are more widely used in Canada and Europe. U.S. programming is largely guided by a model of alcoholism as a unitary disease which one either has or does not have. Other nations address a continuum of alcohol-related problems and place less emphasis on alcoholism as a qualitatively distinct diagnostic group. Greater emphasis is given outside the U.S. to standards and strategies for drinking within safe limits. Compared to Canadian and European systems, nonfederal U.S. programs evidence a highly unusual reliance upon a confrontational disease-focused approach administered by recovering alcoholics. Research-based strategies, more reflected in programming outside the United States, treat alcohol problems within the context of the person's larger lifestyle, environment, and other life problems.

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QUESTIONS FROM SENATOR GLENN AND RESPONSES BY PAUL LUBBEN

1. Would you expand upon your recommendation that Federal and State agencies should support, if not mandate, the increased use of credentialed alcoholism and drug abuse counselors. Are you suggesting that new legislation is needed to establish a minimum performance standard for alcohol and drug abuse treatment practitioners? What standards should apply to the certification of alcohol abuse treatment centers and settings?

2. With the advent of block grants, has there been a reduction in services to the indigent and traditionally underserved populations, such as women, ethnic and racial minorities, and youth? If so, to what extent have these services been reduced?

3. For many years alcohol treatment programs did not address specifically the needs of women and minorities. The Federal Government has tried to encourage changes in this situation through the use of "set aside" programs. Do you feel that these programs should be expanded? Are the set aside programs having their intended effect?

4. Is Congress appropriating enough money through the ADMS and ADTR block grant programs for states to use in their public alcohol abuse treatment programs?

5. What changes or improvements would you suggest be made in the Federal financing mechanisms for alcoholism treatment?

6. What role should Congress play in targeting Federal funds for indigent or underserved populations?

NAADAC
**National Association of Alcoholism
and Drug Abuse Counselors**

3717 Columbia Pike Suite 300 Arlington, Virginia 22204 (703) 920-4644

September 20,1988

Senator John Glenn
Chairman Senate Committee on
Governmental Affairs
Washington, D.C. 20510-6250

Dear Senator Glenn:

This letter is in response to your request for additional information following the June hearings on alcoholism treatment programs.

1) Increased use of credentialed counselors. We are not suggesting new legislation to set a minimum standard. There is currently in place a minimum standard for certification for alcoholism and drug abuse counselors, voluntarily met by the 30 state certification bodies which make up the membership of the Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (CRC). Counselors certified in those states all meet the same minimum requirements in experience, alcoholism and drug abuse specific education, peer evaluation and competency measures.

   NAADAC would support the use of financial incentives to states which have in place credentialing systems that meet this minimum standard and who further require the employment of counselors so credentialed in their state funded treatment facilities. It may be appropriate to add these requirements to the block grant renewal legislation.

   The number of states meeting this minimum standard has grown from 3 in 1979 to 30 in 1988 with a goal of including all states. The CRC provides technical assistance and training to states seeking membership.

   Finally, the provisions of S1265 must be modified to specifically include alcoholism and drug abuse counselors as qualified providers in this Act. The bill's present form does not assure a role in treatment for those professionals although they provide the core of quality treatment presently available in this country.

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Pete Petree, CAC *Southwest*

Stephen H. Kreimer, *Executive Director*

2. Impact of Block Grants.

My understanding is that NIAAA/NIDA currently monitor this area by means of an annual survey. Our experience shows that the states have not always been responsive to the needs of this population and, as a result there has been a reduction in services. The more critical problem is the excess demand for services which current funding levels do not begin to meet. This works against these populations receiving the help they need or results in only limited services: ie, detox only, outpatient only. Access to a full continuum of care is crucial to meet the needs.

3. Use of "Set Aside" Programs

The "set aside" programs are successful and are having their intended effect by providing more focus on the needs of under served populations.

However, those programs remain under funded and experience with previous Federally funded programs which assume state or local funding after several years result in programs closing when this funding is not there. Over all, these programs should be continued and expanded.

4. ADMS And ADTR Block Grants

No, Congress is not appropriating enough money through the ADMS and ADTR block grants for alcoholism treatment programs. In addition,the formula change currently being considered will result in reductions in some states. All states have unmet need.

5. Changes in Federal Financing Mechanisms.

The block grant mechanism in some cases, does not assure that the money is actually spent on alcoholism treatment. The under funding of treatment has resulted in under paid and under trained staff which results in poor treatment. Federal leadership in funding public treatment is needed.
Federal priorities and standards should be set with states held accountable for meeting the Federal guidelines.

6. The Role Of Congress

The Congress must set the priorities and direct the effort. Individual states have not consistently addressed the underserved and indigent populations need for treatment. Innovative programs and providers must be approved for Medicaid and Medicare reimbursement for alcoholism treatment. We critically need a return to clear federal focus and leadership.

Although this response is later than I would like, I hope it will be useful input for you.

Thanks again for your interest and leadership in this area. Please feel free to call on NAADAC if we can be of further assistance in the future.

Sincerely,

Paul Lubben, CAC
President

RESPONSES OF DR. RONALD FLETCHER TO WRITTEN QUESTIONS

1. With the advent of block grants, has there been a reduction in services to the indigent and traditionally underserved populations, such as women, ethnic and racial minorities, and youth? If so, to what extent have these services been reduced?

The Federal ADMS block grant funds started in Ohio fiscal year 1983 (7/1/82 to 6/30/83). Between fiscal years 1981 and 1987, the following changes occurred in admissions to alcoholism treatment programs funded to some degree by the Ohio Department of Health: (a) the percentage of females increased from 15.7% to 23.4%; (b) Blacks increased from 14.9% to 19.0%; (c) Hispanics increased from 0.7% to 1.2%; (d) the age group 18 and under increased from 2.4% to 7.5%.

2. For many years alcohol treatment programs did not address specifically the needs of women and minorities. The Federal Government has tried to encourage changes in this situation through the use of "set aside" programs. Do you feel that these programs should be expanded? Are the set aside programs having their intended effect?

The programs should be expanded to include children of alcoholics and offenders. 25 to 50 per cent of the children of alcoholics will become alcoholics themselves. Nationally, 50 per cent of the inmates of local jails were under the influence of alcohol when they committed the crime for which they were convicted. Additional "set aside" funds should come from new money; to create "set aside" funds from existing money would harm ongoing programs.

In Ohio, 3 percent of the federal block grant is set-aside to be used specifically and solely for women's treatment programs. We now have 37 treatment programs statewide. Special services include residential treatment for women and their children, day-care services for women, and adolescent women's treatment services. During the first year of the programs' operation, 1,170 women received services. In the second year, 2,349 women were served.

As regards the 20 per cent prevention "set aside" of the ADMS block grant, in Ohio these funds are used to augment state dollars which are the mainstay of Ohio's prevention system. The key component of Ohio's prevention system is 50 local prevention coordinators who develop and implement community prevention programs. Current plans call for the evaluation of this system by full-time evaluators during fiscal year 1990.

3. Is Congress appropriating enough money through the ADMS and ADTR block grant programs for states to use in their public alcohol abuse treatment programs?

No. There are an estimated 177,000 Ohioans who are medically indigent and have an alcohol problem or an alcohol and drug problem. 18,000 to 20,000 of them are treated each year in local programs funded by a mix of federal (14%), state (52%), and local (34%) funds. Assuming a recidivism rate of 40 to 60% and an incidence of 5 to 10%, we are barely breaking even. Further, the paucity of needed funds tends to result in a two tiered treatment system. In Ohio, the average cost of treating medically indigent alcoholic clients is $952. In the 1984 Aetna study, the average cost of treating federal employees for alcohol problems was $3,125.

4. What changes or improvements would you suggest be made in the Federal financing mechanisms for alcoholism treatment?

A. The alcoholism funds should flow directly from the federal government to the state department responsible for alcoholism programs. This would make it easier to track the money. The funds could be put to the intended use more quickly. It would reduce the future possibility of inappropriate policies.

B. Fewer "set aside" requirements for alcoholism funds going to the states. Each state is unique. The elected administration of each state is best able to determine the state's particular needs and how to respond to them. If there are to be "set asides", let them come out of new money. That way they won't harm existing programs by reducing their funds.

C. All alcoholism funds going to the states should authorize at least 10% for administration. Included in the cost of administration are not only the costs of managing the funds and monitoring for compliance, but also the cost of evaluation. Without adequate evaluation, it is all but impossible to improve.

5. What role should Congress play in targeting Federal funds for indigent or underserved populations?

Congress should provide adequate funds to meet the needs of the indigent and underserved populations of all the states. Each state is in the best position to know the needs of its citizen and to establish priorities and plans to meet those needs.

6. Could you explain the importance of evaluations of treatment programs in your planning of a state-wide substance abuse policy?

Our drug abuse counterpart in the Ohio Department of Mental Health has assumed most of the responsibility for program evaluation. They have created two new positions dedicated solely to evaluation. A copy of the alcohol and drug abuse program evaluation plan for fiscal year 1989 is attached.

7. Could you discuss some of the ways you have adjusted your programs to the needs of special populations such as women, minorities, and adolescents?

A network of services specifically for women has been created through the Women's 5% Set-Aside project. Program designs have incorporated gender and culturally specific approaches for reaching and treating women. We now have 37 treatment recovery programs statewide.

September 16, 1988

Each year, over 500 Ohio teenagers have the opportunity to attend the Ohio Teenage Institute, which is designed to prevent alcohol and drug abuse among youths through personal development, peer intervention, and local community prevention programs. Every year, we have expanded our efforts to attract inner city minority youth to the Institute.

We have recommended the funding of nine demonstration projects for high risk youth. These projects will: (a) provide prevention and/or early intervention programming; (b) adequately document the process in order to facilitate replication of successful strategies elsewhere in Ohio and the nation. These will be new services to the target population.

For Ohio fiscal year 1989, three of the requirements for regional and subsequently, community programs receiving ADTR funds were: (a) 22% of the funds had to be used for services to youth under 18; (b) in 7 of the 12 alcoholism regions, half of the youth set-aside funds had to be reserved for minority youth because these regions had extreme minority youth treatment needs; (c) in addition, a specific percentage of each region's ADTR funds had to be spent for minority services (the percentage was a function of each region's minority population in relation to its total population).

8. How would you suggest that alcohol advertising on the airwaves be curtailed? Has there been a failure of Federal agencies with regulatory authority over commercial advertising? Is a legislative mandate necessary?

Ban all forms of alcoholic beverage advertising. Nationally over 100,000 people die each year from alcohol related causes. Alcohol abuse costs the country over $116 billion annually. Over 2,300 people a year die from alcohol related problems in Ohio. Alcohol abuse costs Ohioans $5.4 billion annually. The effect of this advertising is especially pernicious on the young. They see beer and wine glamorized in television advertising without any mention of the deadly side effects. $2 billion a year is spent on advertising for alcoholic beverages. With that much money involved it is unlikely the industry will police itself. Congress needs to legislate a ban on all alcoholic beverage advertising.

9. Would your office find it excessively burdensome if the Federal Government required you to provide summaries of your evaluation of the efficacy of different treatment modalities, and types of programs in your annual reports to ADAMHA on your block grant expenditures?

No, it would not be burdensome to create summaries, once the individual program evaluations were available.

PROGRAM EVALUATION

Date: September 6, 1988

Subject: Goals for Program Evaluation for State Fiscal Year 1989 (7-1988 to 6-30-1989)

GOAL 1: Evaluate Federal ADTR Funds.

Objective 1-1. Review application for ADTR Funds. Note purpose of funds.

Objective 1-2. Review request for proposal letter that was sent to Community Mental Health Boards/Regional Councils on Alcoholism soliciting grants/proposals. Note evaluation requirements.

Objective 1-3. Review ADTR grants/proposals that were submitted to BuDA/BAAAR.and that were funded.

Objective 1-4. Review narrative summaries submitted by ADTR receipients for:

--a. Achievement of goals/objectives as stated in grant/proposal application.

--b. Types of services provided.

--c. Number of clients receiving services.

--d. Cost per type of service.

--e. Number of clients receiving services by type of service.

Objective 1-5. Write evaluation narrative of summaries submitted by ADTR recipients.

GOAL 2: Write narrative summary of ODMH's Client MIS output reports.

Objective 2-1. Establish and maintain liaison with ODMH's Information Services office. Identify contact person(s).

Objective 2-2. Review formats of drug abuse output reports.

Objective 2-3. Determine purpose, receipient(s), and how the information of each output report will be used.

Objective 2-4. Review computer runs.

Objective 2-5. Recommend, if appropriate or indicated, revised formats of output reports.

Objective 2-6. Write narrative summary of output data.

GOAL 3. Evaluate High Risk Youth Prevention Grants, which were funded by Governor's Discretionary Funds.

Objective 3-1. Interview State Alcohol Prevention Coordinator and/or State Drug Abuse Prevention Coordinator to determine the purpose of these funds and historical background.

Objective 3-2. Review request for proposal/grant letter that was sent to Community Mental Health Boards/Regional Councils on Alcoholism/Community Programs soliciting grants/proposals. Note evaluation requirements.

Objective 3-3. Review grants/proposals that were submitted to BuDA/BAAAR and approved for funding by the Governor's Office.

Objective 3-4. Determine role of BuDA/BAAAR Prevention Coordinators in evaluation process.

Objective 3-5. Identify evaluation contact person for each project funded.

Objective 3-6. Develop timelines for evaluating funded projects.

Objective 3-7. Develop outcome indicators for evaluating the projects.

Objective 3-8. Conduct at least one on-site visit of each funded project with an evaluation focus for the visit.

Objective 3-9. Prepare quarterly evaluation summary of each funded project.

GOAL 4. Evaluate Federal 5% Set Aside Women Funds.

Objective 4-1. Interview Women Services Coordinator to determine the purpose and historical background of these funds.

Objective 4-2. Review request for proposal letter that was sent to Community Mental Health Boards/Regional Councils on Alcoholism soliciting grants/proposals. Note evaluation requirements.

Objective 4-3. Review 5% Set Aside Women grants/proposals that were submitted to BuDA/BAAAR and that were funded.

Objective 4-4. Review 6 month and 12 month summaries submitted by receipients of 5% Women Set Aside funds for:

-- a. Achievement of goals/objectives as stated in grant/proposal application.

-- b. Types of services provided.

-- c. Number of clients receiving services.

-- d. Number of clients receiving services by type of service.

Objective 4-5. Review monthly statistics submitted by receipients.

Objective 4-5. Write semi-annual evaluation narrative of .5% Women Set Aside Funds.

GOAL 5. Provide technical assistance on Program Evaluation.

Objective 5-1. Maintain liaison with the ODMH Office of Program Evaluation and Research.

Objective 5-2. Provide administrative and technical support to the MIS and Evaluation Committee of the Governor's Council for Recovery Services.

Objective 5-3. Develop a two hour training module on program evaluation for the following.

-- a. Introduction to Program Evaluation.

-- b. Developing Outcome Indicators for Effective Program Evaluation.

Objective 5-4. Provide on-site program evaluation assistance as requested.

GOAL 6. Write narrative summary of ODH-BAAAR's Client MIS output reports.

Objective 6-1. Establish and maintain liaison with BAAAR's MIS section. Identify contact person(s).

Objective 6-2. Review formats of alcohol client MIS output reports.

Objective 6-3. Determine purpose, receipient(s), and how the information of each output report will be used.

Objective 6-4. Review Client MIS output reports.

Objective 6-5. Recommend, if appropriate or indicated, revised formats of reports.

Objective 6-6. Write narrative summary of output data.

Drug and
Alcohol
Service
Providers
Organization of
Pennsylvania

Richard W. Esterly, Chair
Michael Harle, Vice Chair
Sister Michele O'Leary, Secretary/Treasurer
Deborah Beck, President/CEO

RESPONSES OF DEBORAH BECK TO WRITTEN QUESTIONS

DASPOP, 4751 Lindle Road, Suite 111, Harrisburg, Pennsylvania 17111, 717/939-9821

1. With the advent of block grants, has there been a reduction in services to the indigent and traditionally underserved populations, such as women, ethnic and racial minorities, and youth? If so, to what extent have these services been reduced?

The creation of the Block Grant program in 1983, appears to have been intended to provide more local, state control over federal drug and alcohol funding.

Direct grants to local programs were eliminated. In Pennsylvania, individual drug and alcohol programs had succeeded in winning about $4 million a year in direct federal grants.

The creation of the ADM Block Grant had several effects on Pennsylvania:

a. eliminated $4 million in direct grants to individual programs

b. provided more control over federal monies by the single state authority

c. disguised reductions in Federal monies for the state's war on alcohol and other drugs

The single state authority gained more control - but at the price of having to explain federal cuts. Courtesy of some limited forward funding, states were forced to choose between two options: use forward funding to offset cuts and respond to treatment needs in the first year and experience a sharp drop in funding in the next year or phase the federal reductions in over time. To avoid precipitous reductions and sudden impact on programs, Pennsylvania opted for a phase-in approach. This was politically controversial. Some felt it allowed programs to prepare for the reductions gradually and with the least possible disruption. Others felt the phase-in effectively concealed the Reagan Administration's lack of commitment to this problem.

ARC/The Terraces • Abraxas Foundation, Inc. • Addictions Association of Pennsylvania • Caron Foundation •
• Coalition for Addictive Diseases of Southwest Pennsylvania • Diagnostic & Rehabilitation Center •
• Eagleville Hospital • Gateway Rehabilitation Center • Gaudenzia, Inc. • Livengrin Foundation • Malvern Institute • Marworth •
• New Beginning at Cove Forge • Penn Foundation • P.O.S.T. • Serenity Recovery Centers • South Hills Health System Counseling Center •
• St. Francis Medical Center • Talleyrand Retreat • Valley Forge Medical Center & Hospital

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With this background, it becomes possible to address your question directly. What is the impact on traditionally underserved populations? The cliche - Last hired, first fired - seems to fit.

These populations are often destitute and in need of financial assistance if they are to receive care. Given the funding reductions, these populations encounter increased difficulty obtaining needed service. In our state, some programs for the destitute have gone under. Others have switched to serve predominantly the third party health insured. All of our facilities provide alot of free service. However, federal funding for the destitute allowed these free services to stretch and reach much further than they do now. Waiting lists to obtain limited dollars for the destitute and waiting lists for those without funding are exceedingly long.

I've been in the drug and alcohol treatment field since 1971 and I don't ever remember seeing anything quite like this. We used to have to talk people into seeking help. Now they are clamoring to get in and we are forced to turn many away.

Philadelphia county alone reports waiting lists in excess of 1,700 PER QUARTER.

As you know, addictive diseases aren't very patient illnesses. They are not of the sort that can be put aside until care is available. While the individual waits, the disease does not. While the individual waits, there are tragedies in the making. Physical illness, drunken driving, accidents, child abuse, fetal alcohol syndrome, wife battering. The individual's health deteriorates. He/she is unemployable, health care utilization for the attendant illnesses and injuries soar. There may be criminal activity. Damage to family, children and society continues.

2. For many years alcohol treatment programs did not address specifically the needs of women and minorities. The Federal Government has tried to encourage changes in this situation through the use of "set aside" programs. Do you feel that these programs should be expanded? Are the set aside programs having their intended effect?

The set aside program for women and minorities, in my opinion has been a mixed blessing.

First - The impact of such a policy direction being set by Congress cannot be over-estimated. I've worked many years to improve and encourage the provision of just such services. So have many others. The Federal directive was and continues to be heartening to us. Thank you!

Second - The Federal fiscal and state fiscal years are not congruent. Thus the set aside forced the state and counties in Pennsylvania to re-open and alter contracts. This created some political problems and backlash for the programs later established for women. Also, money provided in the first year was for new programs only. The existing women's programs could have used some eligibility for these dollars as well.

Third - Funding provided through this mechanism was/is insufficient to the task at hand. This may have set some programs up to fail. When this happens, old prejudices about the futility of treating these populations are re-awakened and burn anew.

I recommend routine (no guessing from year-to-year) re-authorization of the set aside and also the provision of additional monies to aid these targeted groups. Why? We shouldn't be forced to choose between desperately ill women and desperately ill men.

3. Is sufficient attention being given to the needs of women with dependent children --who need child care services--in residential alcohol treatment settings?

This question is frightfully easy to answer. No - absolutely not. Only five programs that can take women and children exist nationally. Two are in the state of Pennsylvania. All struggle constantly for survival.

The impact of this lack of service is devastating to mothers and children. We spend billions on the effects of alcohol and other drugs on babies, on fetal alcohol and drug effect. We spend billions annually to place children in foster care. We'll spend billions to take families apart - almost nothing to keep them together. (See attached articles and other materials.)

4. In Pennsylvania, are the special treatment needs of women, minorities, the working poor, and adolescents being adequately met by the publically financed treatment system? What suggestions would you make to improve the public treatment system?

No - but not because of any lack of desire. Federal funding cuts to an already underfunded system have taken a quite predictable toll.

Hm. We "treat" these populations alright. In prisons and hospitals, over and over. (See attached article on Pennsylvania's plan to build more prisons. The state Department of Corrections also recognizes that about 70% of the prison population needs drug and alcohol treatment.)

We need a serious and steady influx of funding. The War on Drugs monies have not come close to offsetting the combined effects of Federal cuts disguised as the ADM Block grant and inflationary erosion.

5. Is Congress appropriating enough money through the ADMS and ADTR block grant programs for states to use in their public alcohol abuse treatment programs?

No. Again - the War on Drugs monies - although badly needed - have not offset federal cuts. You can chart the "explosion" of drug/alcohol problems against Federal funding under the last four Presidents. As funding drops, drug problems appear to increase. In '86, in part in response to the explosion of drug problems, the War on Drugs funding began.

This is a familiar cycle for the drug and alcohol effort. Private tragedy accumulates and reaches a flashpoint. There is federal focus and new funding. The problems appear to settle down. Programs are cut or allowed to deteriorate. Private tragedy accumulates. It reaches a flashpoint. We discover there is an alcohol and drug problem in the United States! We tool up. Publicity. Some funding increase...

For once, can we break this cycle?

6. What changes or improvements would you suggest be made in the Federal financing mechanisms for alcoholism treatment?
7. What role should Congress play in targeting Federal funds for indigent or underserved populations?

Congress needs to play an active and consistent role in the alcohol and drug effort. It must be a long term commitment.

I do have a few recommendations. They concern funding. The states now have more local control. Let's give them the resources to do the job.

Alcohol and other drug treatment must be funded under both Medicaid and Medicare. (See the attached material. It contains a suggested amendment or language for a bill. Please use as you need.) Incredible that over 36 states require private insurance to provide this care - but Medicaid and Medicare provide it only in a limited sense. Presently, Medicaid has an incentive match to encourage states to provide hospital detoxification and some outpatient services. The piece of the continuum often needed by patients deteriorated enough to be on welfare IS THUS DENIED to them. Inpatient rehabilitation following detoxification is PRESENTLY NOT PART OF THE FEDERAL INCENTIVE. For this reason, most states do not provide this needed part of the treatment continuum for welfare recipients and the elderly. When the patients get trapped in a revolving door from detox to outpatient

to detox and back - then welfare departments blame the addicted individual or decide they are hopeless.

The present arrangement makes little sense clinically or fiscally. Clinicians know that the most deteriorated patients need the most intensive care. Despite this knowledge, the federal reimbursement scheme discourages appropriate care. Insured patients - usually less deteriorated - can obtain the more intensive care. From a fiscal perspective - MA dollars support the revolving door through detox centers and into hospitals for the attendant ills. The welfare recipient CAN BUY ALCOHOL AND OTHER DRUGS with his/her cash grant but can't buy treatment for the addictive disease.

Another suggestion is to raise federal taxes on alcohol to fund prevention, education and treatment activities. Even a penny tax would raise a great deal of money. This also has some of the features of a user's fee since over 50% of alcohol consumed is purchased by 10% of the population. This 10% tends to have alcohol problems.

Any national health insurance plan devised needs to address the alcohol and other drug issue. This must be part of any such plan and needs to be addressed HEAD-ON - not as part of mental health coverage. The other possible direction to take is to require all states to pass mandated drug/alcohol insurance legislation (most have it) and set minimum standards that are no less than the strongest state law out there. The development of these plans has been a hard fought, state by state battle. Lots of compromise between alcohol/drug people, the business community and labor. You will want to avoid setting any of these efforts back. Another route is to require all states to have such laws at at least some minimum level but not permit any state with stronger packages to regress to the standard.

Alcoholism Treatment Services for Underserved Populations:

Barriers to Effective Service
and
Recommendations for Change

Presented by: Brenda L. Underhill, MS, CAC

Executive Director, Alcoholism Center for Women
Chair, Women's Alcohol Services Task Force of
Los Angeles County
Faculty, Chemical Dependency Studies Program,
California Family Study Center, North Hollywood, CA

to the

Committee of Governmental Affairs

United States Senate

June 16, 1988

I am Brenda L. Underhill, Executive Director of the Alcoholism Center for Women (ACW) in Los Angeles, California. I have been employed by the Alcoholism Center for Women for the past eight years, first as the clinical director, and then as Executive Director for the past six and one-half years. I have worked in the alcoholism field for over thirteen years. My experience prior to ACW was in the provision of direct service to indigent men, and as director and clinical co-ordinator of a teenage alcohol abuse prevention program in New York. I have chaired the Los Angeles County Women's Alcohol Services Task Force since 1983, have been on the faculty of California Family Study Center, Chemical Dependency Studies Program, since 1984, and recently became the co-chair of the National Association of Women in Alcoholism and Other Drug Dependencies. I am an appointed member of the Standards and Certification Committee and the Joint Audit Committee for the State Department of Alcohol and Drug Programs in California.

I welcome the opportunity to address your Committee as to the alcoholism service needs of women and other underserved populations, and the role of the federal government in assuring equitable, accessible, and effective services to these populations.

Overview:

The first issue I would like to underscore is the importance of shifting the conceptualization and specific designation of women and "minorities" to the use of the term underserved, and not "special." To some, this may appear on the surface to be a semantic argument. I submit, however, that the assumption underlying this difference in terminology is pivotal to providing accessible and effective services to the populations under discussion. Using the word special has the direct impact of placing the problem on the individual or supposed minorities. It implies that the difficulties in working with such groups lies with the peculiarities of the group or groups in question, rather than simply acknowledging that the life experiences of these groups is different than the life experience of the alcoholic population that has been most heavily researched and documented, which is the white, heterosexual male, who is free of physical disabilities. Underserved, on the other hand, is a term which is descriptive of the truth of the situation. The literal definition of this term is: "Less than the required amount or degree to meet the existing needs."

We know that alcoholism occurs in all populations. It is often billed as an "equal opportunity destroyer". Yet, statistically, women and other underserved populations are not equally represented in treatment services or research. For example, many leaders in the field often state that they believe that 50% of the alcoholic population is female, but nationally, in publicly funded programs, women comprise only 24.6% of those served. It is believed that the reasons for this under-representation rest in the fact that existing research and service designs have been based on the male indicators and service needs that were mentioned in the previous paragraph, and that these psycho-social dynamics are not readily adaptable to other populations.

We must focus our examination, then, on the systemic and institutional barriers that underserved populations encounter in the alcoholism service delivery system. The terms underserved and under-represented keep us in that framework which is essential if we are to take appropriate corrective actions to assure equal access to quality alcoholism care.

In discussing the issues specific to women and other underserved populations, the basics of what we know to be true for all alcoholics must not be ignored. Regardless as to gender, race, ethnicity, sexual orientation, able-bodiedness, age, or socio-economic status. Alcoholism is a deadly and costly disease, for the individual, the family, and society.

Alcoholism is a primary disease. That is, it is not a symptom of an underlying psychological disorder, an indication of moral weakness or willful misconduct. It is physically, emotionally, cognitively, and spiritually progressive and degenerative. It is chronic in that it is permanent and can only be arrested through abstinence from alcohol and all other mood altering drugs, and is fatal if not arrested through abstinence. It is characterized by relapse, which is a return to drinking, particularly during stressful life periods. Finally, alcoholism, affects all members of the family and all such members need the availability of effective recovery services.

Emotional costs to the individual are high in our society. Four to six individuals are intimately affected by association with one alcoholic, and one third of all families in America report that alcohol use is a problem in their family. The actual financial cost of alcohol problems in America is estimated at 120 billion dollars. Alcoholism and other alcohol problems continue to be the most critical drug issue facing this country, for alcohol is a drug, and not a beverage. Unfortunately, illicit drug use and trafficking provide a more comfortable focus for most citizens, as illicit drugs are not, as a rule, served with the family dinner, advertised in the media, or used to salute heads of states.

Barriers to Treatment Services:

When examining the barriers that women and other underserved populations experience, lack of financial resources must be emphasized. These groups, as a rule, have limited financial resources, including access to third party reimbursement for alcoholism treatment. Ninety percent of all women who have been admitted to the Alcoholism Center for Women's Residential Program are at or below the poverty level. Approximately 55% of our admissions have no address at admission. "Poverty pockets" in our cities tend to be comprised of non-Anglo residents. This lack of financial ability to access health care systems clearly demonstrates why public funds must be equitably allocated to alcoholism treatment services for women and people of color. Many publicly funded programs are tempted by the income of insurance reimbursements to adapt their services to insured clients, thus further reducing services for the poor and working poor.

Historically, alcoholism services and self-help recovery groups were, and continue to be, based on a white male model. While it is true that alcoholism does not discriminate in terms of its victims, unconscious bias in this white male model does result in services being less accessible and effective for populations other than white heterosexual males, thus creating effective service delivery barriers for women and other underserved populations.These barriers include:

(1.) Failure to acknowledge and account programmatically for the differences in sub-groups of alcoholics. Unfortunately, most treatment programs perpetuate and reinforce the myth that ".....an alcoholic is an alcoholic, is an alcoholic, is an alcoholic....." A key component to all treatment programs is education about alcoholism. Few alcoholism curriculums include such information for women and other underserved population. An example of this is that women's alcoholism tends to progress much more rapidly than men's. (i.e.: It has a "telescoped effect".) Alcoholic women show much higher rates of mortality from cirrhosis, circulatory disorders, suicide, accidents, and digestive disorders than do male alcoholics. Women in treatment with shorter drinking histories are too frequently told by their male counterparts in group, "Honey, I've spilled more than you've drank." Since peer feedback is core to recovery, this type of statement only furthers a woman's denial of the seriousness of her alcohol problems. Additionally, cirrhosis of the liver causes approximately twice the number of deaths in the black community as in the white community. Alcoholic cirrhosis causes the death of one in four Native American women. This rate is 37 times that of their white counterparts.

(2.) Our society has a double standard for male and female drinkers, and women who are alcoholic suffer greater social stigma than do male alcoholics. Greater stigma leads to increased denial and isolation. Additionally, providers have been shown to view the woman alcoholic as less motivated, more pathological, and more difficult to serve than men. Alcoholism services must be focussed on increasing women alcoholic's self-esteem.

(3.) The implications of cultural differences between ethnic groups is rarely acknowledged or discussed in recovery programs. A blatant example of this is providers' lack of knowledge of the cultural differences in family norms. Without accounting for these differences, programs will not employ adequate outreach techniques to individual clients of underserved populations, they will provide services that are less relevant programmatically, resulting in a higher drop out rate of the alcoholic and non-involvement of family members.

(4.) Outreach methods are seldom targeted to specific groups. Many providers feel that in order to serve diverse populations, all that they need to do is open their doors. Lack of awareness on the part of the provider results in the use of methods proven to be successful with the dominant culture, but ineffective when applied to underserved populations. For example, outreach through the church in the black and Hispanic communities is a pivotal aspect in the design of services.

(5.) Only a handful of treatment programs nationally provide child care services. Therefore, if a woman with children seeks services, she must literally choose between her recovery (her life) and her children.

(6.) Many alcoholism treatment programs either fail to or refuse to deal with issues related to sexual abuse. It is estimated that 40% to 70% of alcoholic women have been sexually abused. While this issue cannot become the primary focus of early recovery, the abuse needs to be acknowledged in a safe environment. This safety is best provided in all-women's groups with female staff.

(7.) Research in the field of alcoholism continues to exclude a statistically significant percentage of underserved populations. Women in particular are under-researched. The overwhelming majority of research studies are conducted on males, and, even more specifically, those males are often veterans. To my knowledge, not one Pacific-Asian woman has been included in a major treatment research study. Exacerbating the problem is researchers' continued generalization of the results of their studies to all populations. It is one thing to not have specific research information, but this generalization of results perpetuates a generic (non-targeted) approach to recovery.

(8.) Vocational training for women and indigent men is haphazard at best, and does not take into consideration the disenfranchisement that these populations have experienced in the work force.

(9.) A negligible percentage of treatment programs provide adequate bi-lingual services, and even fewer programs make an effort to provide not only bi-lingual, but bi-cultural services.

Overcoming these barriers programmatically in alcoholism programs is essential if equal access to alcoholism treatment services is to be adequately addressed. I firmly believe that we must make a commitment to the inclusion of these issues in governmental plans for policy development and funding.

This is by no means a complete list of the issues that create barriers to women and other underserved populations entering and completing treatment. In summary, these populations share the common characteristics of increased stigma, discrimination, lack of financial resources, and access to effective care. If effective services are to be provided, they must be done by both providing programs that target specific underserved groups, and by the training and education of staff of traditional treatment programs, so that the services are not based solely on the white male experience.

America is a nation of rich diversity. Our alcoholism treatment programs need to reflect that diversity. Not only do we have a moral obligation to provide publicly funded programs for all people who suffer from the devastating affects of alcoholism, a targeted population approach is also very cost-effective. Over thirteen years of experience at my program has demonstrated that services designed for stigmatized groups are effective for more "mainstream" groups, (what I refer to as a "trickle-up effect") but that the reverse dynamic is not true. And now, this experience is finally being empirically documented through research.

Thus, I return to one of my original points. Women and other underserved populations are not "special" groups whose concerns we cannot afford to address in economically difficult times. Working with the most stigmatized groups further advances our knowledge of providing effective services to all alcoholics.

The Federal Role:

If we, as a nation, are to adequately address the alcohol problems of women and other underserved populations, it is extremely important that the federal government take leadership. N.I.A.A.A. was an example of such leadership. The direct grant program of N.I.A.A.A. resulted in many innovative and effective programs for women and other underserved populations. My own program, the Alcoholism Center for Women, is such an example. Opened in 1974, with an initial six years of federal funding, we have been able to become the largest comprehensive publicly funded non-profit women's alcoholism recovery and prevention services program in the nation. However, with the changes to N.I.A.A.A., which resulted from the Omnibus Budget Reconciliation Act of 1981, the Institute's role in treatment was transferred to alcohol, drug, and mental health services block grant administered by the Alcohol, Drug Abuse, and Mental Health Administration. Funding for treatment was reduced by 40%. ACW. had the benefit of six years in which to establish ourself and broaden our funding base, and were able to integrate into the local planning process. Many N.I.A.A.A. programs were not as fortunate as we were, and did not have as much time, nor were they able to garner enough community support for services to their target populations, and they were forced to close their doors. Time and time again, service providers face hostile neighborhood groups as they attempt to provide shelter, recovery, and rehabilitation services to alcoholic women, indigent alcoholic women and men, and people of color.

In addition, N.I.A.A.A.'s much-needed data system was lost. Federal treatment standards, a movement in it's infancy, was also lost. Research on the psycho-social aspect of alcoholism became a low priority of N.I.A.A:A. This type of research is critical to understanding the interplay of the disease of alcoholism and the social realities of people's lives. The lack of this type of research particularly affects underserved populations, since they are the most under-researched.

I am here today to say that the loss of N.I.A.A.A. and overall federal leadership in alcoholism treatment and prevention has been a severe blow to women and other underserved populations. The belief that local communities would adequately provide for these groups through the block grant program has not proven to be true. Stigmatized groups such as women, people of color, and people with disabilities, gays and lesbians, and the aging, are not given priority by local communities. It has taken the "Lancaster Bill" in the State of California to force counties to demonstrate how they plan to meet the needs of women and other underserved populations.

Refusal to prioritize services for women has recently been further demonstrated in California with the resistance by some county administrators to incorporating and supporting the programs which resulted from the five percent women's set-aside of the Alcohol, Drug Abuse, and Mental Health Services.

Not only does the federal government need to create more legislation mandating services to underserved populations similar to the women's set-aside, but it is imperative that these funds be at least monitored, if not administered, by the federal government. A local example in Los Angeles underscores my point: The 1986 "war on drugs" monies did not result in increased services for alcohol programs in Los Angeles County. Although the Los Angeles County Alcohol Plan clearly delineates the needs and priorities of that county, the plan was disregarded. Los Angeles County presently faces another such diversion from our planning process, which could result in a one-third reduction in our alcoholism service delivery system.

Recommendations:

I have only touched upon the issues pertinent to the myriad of problems related to the lack of effective services for women and other underserved populations. The common denominators that shared by these populations are higher stigmatization, minimal targeted outreach, a serious deficiency in research that is focussed on these populations, a lack of effective and accessible service, and service providers' lack of knowledge and biases where these populations are concerned.

It is the experience of the Alcoholism Center for Women that when services are designed to meet the specific needs of the people they are targeted for, that when serious outreach is made to a specific group, that when the composition of program staff reflects the clientele it serves, and when program content is made relevant to the life experiences of participants receiving services, people utilize those services, with a significantly higher rate of success.

The problems that all of these underserved and underrepresented populations encounter are the results of a generic white male outreach and treatment model being imposed upon them by the alcoholism service delivery system. The issues of the underserved and the unserved are directly related to lack of accessible and affordable care, sensitive to and designed to meet the needs of the realities of their life experiences.

It is absolutely appropriate for the federal government to assess needs, and, when gaps in services to specific groups exist, to take leadership in earmarking funds, and developing service guidelines, for these populations.

The community demonstration grant projects for the homeless was a recent example of such leadership. I offer the following specific recommendations:

(1.) An increase in ADMS Block Grant funding with specific earmarking of funds for services for underserved populations.

(2.) An accountability mechanism which assures that these new funds for alcoholism services not supplant existing service dollars.

(3.) The establishment of a new research center on women, with specific emphasis on women of color, lesbians, women with disabilities, senior women, homeless women, and women with children, funded through N.I.A.A.A.

(4.) A return to the direct treatment funding by the federal government of underserved populations through N.I.A.A.A.

(5.) N.I.A.A.A. conferences focussed on underserved groups, and the dissemination of information on women and other underserved populations by N.I.A.A.A.

(6.) Increased efforts to train professionals (gatekeepers) who are likely to come into contact with women and other underserved populations, and who are in an excellent position to do early intervention. Projects which are directed at the cross training of professionals prove to be extremely effective. ACW's "Double Jeopardy", (one of the women's set-aside programs), which trained domestic violence program staff in alcoholism, and alcoholism service providers in domestic violence, is an example of this type of training.

(7.) Increased funding to N.I.A.A.A. for a comprehensive national data collection system which provides information on client characteristics, descriptive patterns of the underserved's service utilization, and the identification of high risk groups.

(8.) A federal focus on Alcohol As the Number One Drug Problem our nation faces.

(9.) A resolution by Congress acknowledging alcoholism as a disease. This would have an enormous impact in decreasing the stigma of alcoholism for all populations.

(10.) A continuation of the women's set-aside funds.

(11.) Development of national alcoholism treatment standards which are sensitive to gender, race,ethnicity, culture, age, sexual orientation, and physical disabilities.

The first step is to acknowledge the enormity of the price that our nation pays for the lack of a comprehensive national alcohol policy. The liquor industry profits well from our denial that alcoholism is the third largest public health problem in America.

Your Committee is to be applauded for its work. It is one of the few recent efforts to assess the need for strong national policies in regards to alcohol, alcoholism, alcoholics, and their families. We must, as a nation, continue to ask the questions that need to be asked, and, together, to take up the challenge to change both our vision and our practice. Working together we can reduce the stigma of alcoholism, remove the barriers to treatment, and, through sane alcohol policy, reduce the alcohol related problems significantly in our life times.

STATEMENT OF MR. JOHN A. JACKSON, JR.
ADMINISTRATOR,
ALCOHOL AND DRUG ABUSE SERVICES ADMINISTRATION,
COMMISSION OF PUBLIC HEALTH,
DEPARTMENT OF HUMAN SERVICES
DISTRICT OF COLUMBIA
ON
ALCOHOL-RELATED TOPICS
TO THE
COMMITTEE ON GOVERNMENTAL AFFAIRS,
U.S. SENATE,
JUNE 16, 1988

Good afternoon, Chairman Glenn and members of the Committee, ladies and gentlemen. It is a pleasure to have an opportunity to discuss the programs and experiences of the District of Columbia's Department of Human Services, Alcohol and Drug Abuse Services Administration (ADASA) as related to alcohol abuse. We welcome the opportunity to appear before you, and consider it a privilege.

The focus of your hearing is on alcoholism. This focus could not be more timely. It is not just important, but perhaps crucial at this time to consider very carefully what the effect of alcohol abuse is upon our population. The current, and understandable emphasis upon our War on Drugs may serve to overshadow one of the most significant battles of this War – the battle against alcoholism. While less attention is being placed on this particular battle, we as a nation are closer, in fact, to losing the fight against alcoholism than against drugs; statistics show that drug use in general has been going down for several years now, while a turnaround in alcohol consumption has only just begun to appear, and may reflect more a change away from consumption of spirits to other alcoholic beverages than a true decline in usage.

First, for the sake of filling in background and the record, let me offer you a few facts about alcohol problems in the District, the Alcohol and Drug Abuse Services Administration and the alcoholism programs it offers.

The District has the dubious distinction of having the highest per capita alcohol consumption in the country. While this figure is skewed by alcohol sales data which include purchases by tourists, commuters and a large international clientele, nevertheless our alcohol problem here is substantial. The District's State Health Planning Agency estimates that approximately 74,000 residents have an alcohol problem, with an estimated 14,000 of them being 19 years of age or younger. In the District, alcohol is considered the leading co-factor for accidents, homicides and suicides, as well as a major cause of many health-related deaths. The District leads the nation in the number of cirrhosis deaths per 100,000 population. Among our young people, a 1986 survey of substance abuse among junior and senior public school students in the District of Columbia reveals that about 35% abstained from alcohol, as compared to a 54% abstention rate in 1980. The 1986 surveys reveals that:

- The prevalence of alcohol use among District youth is slightly greater than the national prevalence rates but consistent with that of other large cities;

- Approximately 67% of District junior and senior high school students have used alcohol at least once;

- Parents and/or family were the primary first source of beer or wine, and

- Approximately 9.4% of the students who use alcohol, drink beer or wine weekly, and 4.6% drink hard liquor weekly. The rate of beer and wine use rises from 33% for 7th graders to 65% for 12 graders. For hard liquor, the rate of use rises from 14% among 7th graders to 34% for 12 graders.

The ADASA provides a comprehensive system of treatment services offered free of charge to residents of the District of Columbia. Between our city-operated and our contracted programs, we provide a full spectrum of treatment services at 24 locations throughout the city. We are capable of treating approximately 4,000 people in various modalities at any given time. Appended to this testimony is information describing our alcohol patient profile, as well as information on each of our alcohol programs, and information on contracted and direct-service programs aimed specifically at assisting youth with poly-drug problems, including alcohol.

Historically, alcoholics in treatment at ADASA have received a different set of services from those offered by ADASA to drug addicts. This split is reflected administratively in the two separate ADASA bureaus offering treatment - the Bureau of Drug Treatment Services and the Bureau of Alcohol Treatment Services.

To some degree, this split reflects the effect of different municipal and federal statutes governing treatment modalities for alcoholism and drug addiction, and to some degree it reflects a now-diminishing split between "pure" alcoholics and "pure" addicts. These differences, both bureaucratic and socio-medical, have now become much more blurred. While the split remains, managerially, i.e., ADASA continues to maintain two separate bureaus at this time, clinically it is much less meaningful than it once was. We are melding a considerable portion of our actual service delivery.

This change reflects the change in our clientele. We are now seeing many more poly-drug users than before, and especially among cocaine patients. We do not see many persons any more who are strictly alcoholic. This is particularly true among our younger clientele who are almost exclusively poly-drug abusers. Almost all of our patients are mixing drugs, or alcohol with drugs.

Nowhere is this more true than among our cocaine-abusing clients. They, even more than heroin or PCP abusers, seem to be particularly inclined to mix cocaine with alcohol.

It is ADASA's observation that these cocaine and alcohol-mixing clientele are able to drink considerably more alcohol with less effect than if they were drinking alcohol alone. Possibly this may come about because alcohol is a "downer" and cocaine is an "upper" – the stimulating effect of cocaine possibly canceling out some of the depressing effects of alcohol. This synergism is a new outcome that bears watching, as it has important implications for the direction of substance abuse in general, and in the actions of these abusers.

You have indicated that you are interested in how the ADASA has responded as poly-drug use has increased. I am delighted to share the direction of our planning with you. We are currently developing what will be an amalgamated recovery program that in time we intend to implement. This program will offer a continuum of care to all incoming patients, beginning with in-hospital detoxification if needed, proceeding to a multi-week inpatient program (Karrick Hall), then to a halfway house situation (Mary E. Herring Home), and finally to outpatient status. This continuum will be offered to patients as appropriate, regardless of whether alcohol or drug abuse is the primary diagnosis. We intend eventually to shift from an alcohol or drug model to a poly-drug model, expanding our program at the same time, because we believe doing so will increase the chance of recovery among our patients. We have tried this out experimentally on a very small scale, and found that it has worked well with patients suffering from cocaine/alcohol abuse as well as with heroin/alcohol and PCP/alcohol abusers.

You have asked about treatment for those unable to pay. Let me respond that we treat first, and ask questions later. No treatment is withheld because of an individual's inability to pay. In point of fact, most of our clients do not have the means to pay for the services offered. Occasionally, third-party payment is realizable. We operate under the requirements of the Hagan Act.

On the question of our perception of the need for targeting federal funds for historically underserved populations, such as women, the homeless, minorities and the working poor, let me answer first by stating that we offer help to each of these groups. We have a clinic located on the grounds of D. C. General Hospital, specifically for women substance abusers, with emphasis on women of child-bearing age. There we offer a full range of gynecological, pre- and post-natal and support services contract with D. C. General Hospital, utilizing federal funds. Through a contract with S.O.M.E. (So Others May Eat), we offer mobile substance abuse counseling to the homeless. As most of the substance abusers in the District are Black, our services are aimed precisely at this population. In addition, we have contract programs aimed at serving the particular needs of Hispanics, homosexuals and the hearing-impaired. Each of these populations has needs which can best be served by making use of existing organizations within that community.

On the question of the working poor, we have found that we have been able to stabilize something like half of our clientele sufficiently for them to be able to work. We encourage our clients to work, and support them in so doing by offering both early and late hours at our clinics.

On the larger question of the appropriateness of targeting in general, I must tell you that I am an advocate of the least amount of targeting possible. Targeting locks funds in, and in the substance abuse field, change is a constant! The type of drug favored at any given moment is subject to dynamic shifts – witness, here in Washington, the long-term decline of heroin, and the precipitous shift from PCP to cocaine among non-opiate, poly-drug abusers. The usage patterns of younger drug abusers are particularly subject to change, and it is in our best interest to be able to respond quickly to these shifts. In order to respond quickly and appropriately to these swings, we need to be as flexible as possible. If major portions of our funds were tied down, it would be difficult for us to respond to the needs of our patient population effectively or on a timely basis. As a manager, I do not want to be denied the maximum feasible flexibility in doing my job.

Finally, I would ask you to consider alcohol abuse in the District in the context of poly-drug abuse. As I pointed out before, there are very few alcoholics in the District who are not at the same time, abusers, to a greater or lesser degree, of some other controlled substance as well. This means that we must respond to each of these abuse problems if we are to help our patients become sober and drug-free. We cannot ignore the intertwining nature of these addictions if we are to offer successful treatment. We have had what has been historically a very successful inpatient/halfway house/outpatient program for alcoholics. It is our intention to extend this potential for success to patients who are dependent not only on alcohol, but on other substances as well. This shift to poly-drug usage is, I believe, not only in the District, but nationwide as well; I would be most interested to learn what your other witnesses may have to say on this subject. I hope that my testimony has been of assistance to this committee, and I stand ready to provide any additional information you may find useful. Thank you.

MAY 21 1990.

PREVENTING ALCOHOL ABUSE

Written Testimony
to the Governmental Affairs Committee of the
United States Senate

Prepared by Marcus Grant*

1. Introduction

In recent years, alcohol-related health and social problems have become an increasing cause of concern in many developing and developed countries. That concern has not been confined to individual countries, but has also found expression at the international level.

Ever since the First World Health Assembly in 1948, WHO has recognized that it has a role as the focus for international concern about alcohol-related health problems, where health is defined not merely as the absence of disease but as a state of complete physical, mental and social wellbeing. Since alcohol-related problems affect virtually every area of psychosocial functioning, it is evident that WHO's mandate implies a clear commitment to the alleviation of these problems. It is important to emphasize at the outset that WHO's concern is therefore with the prevention of a very wide range of alcohol-related health problems.

In setting about the task, WHO's aim is to investigate and develop technologies that will enable individuals suffering from the alcohol-dependence syndrome and from its associated problems to be more rapidly identified. A further challenge for WHO is to develop preventive strategies that will reduce alcohol-related mortality and morbidity and to promote these strategies to Member States, WHO is also investigating treatment approaches, focusing particularly on simple interventions.

Another reason why WHO takes a particular interest in the question of alcohol-related problems is that such problems are now being reported in increasing frequency from countries that had previously been relatively free from them. While alcohol consumption and alcohol-related problems are beginning to level off in some developed countries in Europe, for example, they are showing signs of increasing in a number of developing countries in Africa, the Americas, and the Western Pacific. Certainly, representatives from many countries in those regions of the world are expressing growing concern at the extent to which such problems are increasing there. WHO has particular responsibility to prevent disease and to promote health in developing countries, so that such expressions of concern require to be taken very seriously indeed. Nor is it sufficient to recommend improvements in the provision of treatment services. In view of its global responsibility to work with countries to prevent alcohol-related problems, it is essential that WHO should be in a position to offer advice on all relevant aspects of alcohol policies, including the question of availability.

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In keeping with the expressed concerns and priorities of the World Health Assembly, WHO supports Member States in their efforts to reach decisions on prevention of alcohol-related problems which are consistent with their national needs and circumstances. In recent years, for example, it has conducted a series of studies and workshops relating to development of national alcohol policy. These efforts have been carried out at headquarters and regional levels, with collaborating governments and research institutions, and have produced a valuable body of reports and publications (Moser).

2. Current trends in alcohol consumption and alcohol problems

The most important lesson to emerge from recent research is that trends in alcohol-related problems are generally positively associated with those in alcohol consumption. In the report of the WHO Expert Committee on Problems Related to Alcohol Consumption (WHO Expert Committee), it is pointed out that, while the association between consumption and problems cannot be described in precise mathematical terms, a considerable body of empirical evidence supports such an association. Studies of individual countries over time and comparative studies of different countries and regions have demonstrated this association most convincingly for liver cirrhosis, but there is also evidence relating both to other alcohol-related diseases and to indirect indices, such as arrests for drunkenness.

After reviewing a number of qualifying variables that have to be taken into account in assessing the validity of this association, the Expert Committee concludes that "in spite of all these considerations, the available evidence suggests that, in a given cultural setting, an increase in consumption tends to be accompanied by an increase in potentially harmful drinking, whatever the specific consequences for each country and each drinking culture".

Figure 1 shows the level of consumption of alcoholic beverages (in litres of pure alcohol per adult) around 1977, the most recent year for which data are available and the increase in beer consumption from 1960 to 1981 for a selected number of countries in different world regions. The figures on which the consumption levels are based consist of all commercially marketed alcoholic beverages, including beer, wine and distilled spirits. As figures on the changes in wine and spirit consumption over time are not available for most developing countries, the increases which are illustrated for selected regions refer only to beer consumption. Although beer only covers about 40% of total world consumption of commercially produced alcoholic beverages, there are specific reasons to concentrate on beer in order to obtain an adequate picture of the process which took place during the observation period. A comparison of the world production figures for beer, wine and spirits between 1965 and 1980 shows that the very slight increase in wine production as well as the more considerable growth of spirits production was mainly concentrated in the traditional wine or spirits-consuming countries in the developed world, whereas in increase in beer production was above all due to an increase in less developed areas. Available trade statistics show that these trends are not neutralized through international trade.

As shown in Figure 1, heavy consumption of alcoholic beverages (above 15 litres per adult) is mainly a feature of certain western and southern European countries, The consumption levels of most of the other developed regions of the world, namely Northern America, the remainder of Europe, Australia and New Zealand, are also comparatively high (10-15 litres of pure alcohol per adult each year). With few exceptions, the average consumption levels of Central and South America and the Caribbean countries are considerably lower than those of the developed countries (less than 10 litres per adult). The adult populations of Asia, Africa and Oceania typically have a very low intake of alcohol (less than 5 litres per adult).

Looking at the rates of increase in beer consumption per capita between 1960 and 1981 in selected regions of the world, it appears that the regions with low consumption show extremely high growth rates (over 600%), whereas the countries with high consumption show comparatively moderate increases (about 40%). In the case of the African countries presented, this increase brought their consumption level relatively close to that of Europe and Northern America in 1960. The Central and South American countries and the two countries presented from East Asia have also reached a considerable level of beer consumption within a time period of only 20 years in comparison with their very low starting point.

3. Considerations relevant to preventive policy

It is clear that Member States wishing to prevent alcohol-related problems face many difficulties - among them, diffusion of relevant governmental authorities, opposition of economic interests, and uncertain public support. These considerations are relevant in both developed and developing countries, but it is important to emphasize those which are especially relevant to developing countries.

(a) Alcohol-related problems manifest themselves differently in different cultures (in part, because drinking practices differ) and at different stages of socio-economic development. Nonetheless, in many of the forms they take, across many cultures, they tend to increase as per capita consumption of alcohol increases. In many developing countries, the general outlines of such problems are already apparent. For example:

> In Swaziland, "... our outpatient departments are filled on Monday by victims of weekend drinking, our wards are filled with cases of

> cirrhosis of the liver, hemorrhaging gastric varicosities, ataxias and peripheral neuritides ... We also know the loss to industry and the civil service of young middle-aged men who drop out because of addiction. The mental hospital figures of psychoses directly due to alcoholism are fairly constant, at 20 to 25% of admissions ... The figures from the High Court ... are also striking. Of the 97 cases of murder or culpable homicide heard during 1978 and during 1979 till November, drink played an important role in 58, that is, about 60%. Drunken driving cases are frequent in the subordinate courts and are assuming alarming proportions." (Reinhold).

(b) The "long gestation of many of the chronic physiological consequences of drinking does not make these problems less important to developing countries; even where overall life expectancy is low, the life expectancy of those who survive to 'drinking age' is quite high" (Room, unpublished draft). Thus, developing countries in which per capita consumption of alcohol has increased greatly over the last 20 years - and whose experience of alcohol-related problems to date may have consisted largely of traffic accidents, accidents in the workplace, violence, and malnutrition of children - can anticipate, in addition, a "substantial 'epidemic'" of the long-term physiological consequences of alcohol consumption in the near future (Room, unpublished draft). The additional strain on scarce economic and social resources will be considerable and, in the absence of vigorous efforts to prevent alcohol-related problems, will continue to grow.

(c) Many developing countries are themselves eager to encourage the growth of domestic alcohol industries. Brewing, in particular, can seem an attractive proposition in the early phases of industrialization. The technology is relatively simple, the required capital investment is not large, it uses agricultural inputs, it provides a base for other industries (for example, glass and packaging). It also "serve(s) as a source of state revenue and obviate(s) the use of foreign exchange for imported beverages" (Room, unpublished draft). For example:

> In Zambia, between 1969 and 1980, recurrent revenue to the government from the alcohol industry increased more than five-fold (as a result of

annual increases in the price of alcoholic beverages) while total recurrent revenue to the government less than doubled. By 1980, revenue from the alcohol industry comprised 15% of total government recurrent revenue (up from about 5% in 1969, having peaked at about 19% in 1979). In 1979-1980, the turnover of the Breweries Division comprised an estimated 41% of the total turnover of the Industrial Development Corporation of Zambia, Ltd. (up from 23% in 1970-1971). Employment in the Breweries Division is nearly one-quarter of total employment of the companies owned by this government holding company, which produces more than half of the manufactured output of the nation (Serpell).

(d) Retailing of alcoholic beverages also offers attractive investment opportunities. For example:

In Botswana, "10% of the medium-sized loans made by the National Development Bank are for bottle stores and bars" (Report of a Meeting on Community and National Response to Alcohol-Related Problems, 16-21 November 1981, Lusaka, Zambia, Part II).

In Zimbabwe, in 1983 alone, the number of liquor licenses issued increased "nearly 50% for Harare District and 20% and over in 13 other districts. In one district only ... was the increase under 10%" (Zimbabwe).

(e) Domestic production of alcoholic beverages, whether commercial or non-commercial, requires agricultural products and water, which in many developing countries are in very short supply. Such countries will want to consider the implications for nutrition and health status of devoting scarce agricultural land, foodstuffs, and water to the production of alcoholic beverages. For example:

In India, "the moral question of wastefulness with foodstuffs has played a large part when alcohol has been debated publicly ... To use the inadequate production of cereals and other foodstuffs for the

> manufacture of alcoholic beverages is regarded as a mark of civic irresponsibility" (Armyr et al.).

(f) Undernourished persons may be more vulnerable to alcohol-related problems than those with an adequate diet; this may reinforce the harmful effects of alcohol consumption in developing countries in which malnutrition is prevalent (WHO Expert Committee).

(g) In developing as well as developed countries, measures which affect the price, production, distribution and sale of alcoholic beverages can be difficult to enforce. For example:

> In Mexico, a "law prohibiting the opening of liquor stores near industrial parks, health facilities, or schools has been rendered moot by the explosive growth of Mexico City and the proliferation of these facilities" (Medina-Mora).
>
> "In most Caribbean countries, there is a legal age limit, but children walk into supermarkets and buy alcohol without being questioned" (Beaubrun).
>
> In "many developing countries ..., centralized price policies have little bearing on the considerable non-commercial production of alcoholic beverages" (Mäkelä et al.).

(h) In many developing countries, it is possible to identify traditional cultural, religious, and social norms which will support efforts to prevent alcohol-related problems. Recognition that alcohol-related problems interfere with desired social and economic development can also encourage public support.

(i) In developing as well as developed countries, the possibilities for effective community action to prevent alcohol-related problems, independent of measures taken by government, should not be overlooked. For example:

> In Honduras, in the barrio of Santa Eduviges, "by a community decision, the local food store no longer sells alcohol. [Santa Eduviges, a barrio of 60 houses and 300 people, is located in a district of high unemployment and low wages marked by family instability, violence, and alcoholism]. Although alcohol is still readily available from nearby outlets, the insistence that it should not be sold locally reflects a change in community values [which evolved in the course of its participation in a mental health/community development project initiated in 1975] that has been accompanied by a decrease in the frequency and severity of alcohol-related problems" (World Health Organization).

4. International evidence on the effectiveness of preventive measures

Many measures which might prevent alcohol-related problems have never been systematically evaluated. And current knowledge is insufficient to permit detailed advice on a great many technical points important to the development of effective national policies. But the scientific evidence summarized here does support two confident - and hopeful - conclusions:

- Alcohol-related problems can be prevented.

- They can be prevented by measures which governments can take.

In fact, history offers ample evidence that alcohol-related problems not only rise but also fall, often very rapidly. Such changes have occurred in both developing and developed countries, in many historical periods. In recent times, national trends in alcohol-related problems have been largely upward. However, there are also clear recent instances in which they have been halted or even reversed. For example:

> In France, between 1956 and 1982, per capita consumption of alcohol declined nearly 27%: from more than 26 litres of ethanol per person aged 15 years or more to just over 19 litres. And decreases in significant alcohol-related health problems have followed. Between 1975 and 1982, the death rate from cirrhosis of the liver declined 21%

for both men and women. Between 1960 and 1982, the death rate from alcoholism/alcoholic psychosis declined 43% for men, 53% for women.

4.1 Measures for which there is reasonably good evidence of effectiveness

4.1.1 Increasing the relative price of alcoholic beverages

The sum of scientific evidence and historical experience affirms that, other factors being constant, an increase in the price of alcoholic beverages relative to other commodities generally reduces per capita consumption.

More recently, there is also explicit evidence that the price of alcohol, acting through its effects on consumption, influences the level of alcohol-related problems. For example:

> In Trinidad and Tobago, between 1966 and 1975, the number of road traffic accidents per year "rose and fell predictably ... with changes in the price of rum relative to per capita income" (Kendell et al.).
>
> In Scotland, in 1981, a combination of tax and price increases caused the price of alcoholic beverages to increase faster than the retail price index and average disposable income. Unemployment rose simultaneously. Surveys of "regular drinkers" conducted in Edinburgh and the surrounding area in 1978-79 and again in 1981-82 indicate that, between surveys, total alcohol consumption fell by 18% and associated adverse effects by 16%. Although rising unemployment was responsible for up to one-fifth of the reduction in consumption, "the increased price of alcohol was the major influence. Heavy drinkers and dependent drinkers both reduced their consumption at least as much as light or moderate drinkers and suffered fewer adverse effects as a result" (Kendell et al.).

Increasing the price of alcoholic beverages may deprive the families of some drinkers who are poor. However, there is little reason to believe that poor drinkers are less likely than other drinkers to reduce their alcohol consumption in response to price increases. And, to the extent that consumption does decline in response to higher prices, both family income and the health of the drinker may improve (Moore & Gerstein).

In sum, increasing the price of alcoholic beverages relative to other commodities can be expected to reduce consumption (by heavy drinkers as well as others in the drinking population), and, thus, to prevent alcohol-related problems.

4.1.2 Sharp restrictions on the distribution of alcoholic beverages

Sharp restrictions on the distribution of alcoholic beverages (as illustrated by periods of rationing, prohibition, and strikes in the distribution system) significantly reduce alcohol-related problems. For example:

> In Canada, Finland and the United States during the first few years of prohibition, with the exception of automobile accidents, "all indicators of alcohol consumption and alcohol problems reached the lowest level yet achieved in any period for which there are relevant data" (Bruun et al.). It is estimated that, in the United States, total alcohol consumption declined sharply during the early years of prohibition, then rose somewhat toward the end of the 1920s (Aaron & Musto).
>
> In Norway, in 1978, a nine-week strike of production, storing, and transport workers at the Norwegian Wine and Spirits Monopoly stopped deliveries of wine and spirits to all retail outlets and licensed premises. However, retail sales of wine and spirits continued until stocks were exhausted and beer was on sale as usual. Sales of beer, imports of wine and spirits, home production of wine, and illegal home distilling all increased during the strike period. The estimated decrease in total alcohol supply was approximately 10-15%; the estimated decrease in total alcohol consumption was 5-10%. Nonetheless, "most measures strongly influenced by skid-row alcoholics, i.e., admission to detoxification centres, the use of detoxification rooms at the so-called protection homes, reports of drunkenness, drunkenness

arrests, offenses called 'home quarrels', number of drunkards in the street, and injuries caused by falling, showed a marked decrease" (Horverak).

In Poland, in 1981, the rationing of alcohol "involving a 20% overall drop in consumption, was accompanied by declines of 11% in cirrhosis deaths, 39% in admissions to sobering up stations, and 40% in first hospital admissions for alcoholic psychoses" (Room).

Moreover, as the examples indicate, it is not simply moderate drinkers whose consumption is influenced by such general changes in the availability of alcoholic beverages. In fact, "it is precisely the heavy drinkers most likely to appear in ... casualty and crime statistics whose behavior often seems most strongly affected" (Room).

4.1.3 Increasing the minimum legal "drinking age"

Lowering the minimum age at which a person may legally purchase alcoholic beverages (or at which alcoholic beverages may legally be sold to him) frequently increases the rate of automobile accidents among young people, sometimes including young people not yet of legal "drinking age" (Wagenaar).

Although these findings are limited to Canada and the United States, they are relevant to many countries in which motor bicycles are widely used by the young and/or in which alcohol-related motor vehicle accidents are a major cause of death and injury among young people. They may be relevant also to countries which have very low minimum age requirements or none at all.

It should be noted that minimum age requirements are often seen as expressing and communicating society's view of appropriate conduct - and, for that reason, as having important symbolic effects in addition to their demonstrated impact on automobile accident rates.

4.1.4 Increasing the probability of detection and punishment for drinking and driving

Increasing the probability of detection and punishment for drinking and driving reduces deaths and injuries in traffic accidents.

Both the actual probability of detection and punishment and the public's perception of that probability are crucial to sustained effectiveness. The critical elements of action to this end include:

- making driving with a blood alcohol concentration (BAC) higher than a specific level a legal offence in itself;
- requiring that BAC be established by chemical tests (for example, of blood, breath, or urine);
- requiring police to test BAC at roadside if a driver is involved in an accident or a traffic violation or permitting police to stop drivers and test for BAC at roadside without any prior evidence of possible drinking; and
- imposing punishment considered "severe and depriving" for driving with a BAC above the legal limit (for example, mandatory suspension of driver's licence) and applying it also for refusal to submit to the tests.

These conclusions emerge from the cumulative experience of several countries. In particular:

> In the United Kingdom, in 1967, the law was amended to define driving with a blood alcohol concentration of 80 mg/100 ml or higher as an offence and to permit police to demand a roadside breath-test (to screen for blood-alcohol concentration) if a driver were involved in an accident or a "moving" violation of traffic law or gave reasonable cause to the police to suspect he had been drinking. "Refusal to take part in the tests was punishable as though the tests had been failed".

(Since 1962, the law had required a year's suspension of driver's license for serious motoring offenses, including drinking and driving). Enactment and implementation of the 1967 law were accompanied by substantial controversy and resulting publicity and "road casualties declined impressively" in the months subsequent to its implementation. In particular, fatal and serious injury crashes on weekend nights ("in which alcohol is much more commonly involved ... than at other times") dropped 66% in the first month, "an unprecedented and highly significant decline". "For the three months following the passage of the act, casualties from traffic accidents were reduced 16% from the same period the previous year, and fatalities were reduced 23%". The percentage of all drivers killed in England and Wales who had illegal blood alcohol concentrations declined from 25% in December 1966 - September 1967, prior to the implementation of the law, to 15% in the corresponding period of 1967-68 (Ross).

Similar measures were subsequently adopted in France, the Netherlands, Canada, and New Zealand - with some impact initially (though less than in the United Kingdom) and a similar decline in effectiveness over time. The initial effectiveness of these laws has been attributed to "overestimation of the probability of punishment" for drinking and driving, "produced by the publicity and newsworthiness of the new laws". The eventual decline of their effectiveness, to drivers "learning through experience" that the actual probability of punishment, even if much increased, was considerably lower than they had originally estimated, in some cases remaining "negligible".

In sum, "(t)here is good evidence that if drivers in general perceive a high risk of being arrested if they drive drunk they will be deterred from doing so, and alcohol-related traffic accidents will decrease substantially" (Reed).

4.2 Measures widely believed to be effective, though little scientific evidence is currently available

4.2.1 Education of school children and the general public

Neither individual school-based alcohol education programmes nor public education campaigns via the mass media have proved effective in reducing alcohol-related problems - though, in the short-term, they not infrequently increase knowledge and sometimes change attitudes. These findings are generally attributed to methodological weaknesses in evaluations of the programmes and/or in the programmes themselves (for example, failure to define objectives or target groups with sufficient precision).

A few experimental efforts to encourage and support behavioural change in a health-enhancing direction have succeeded in reducing health risks. These programmes had several critical elements in common - among them, the following:

- They attempted to change several types of behaviours associated with adverse health effects.

- They combined mass media campaigns with other measures.

- They were based in and involved the community.

The implications of the literature on school-based alcohol education (whether it conveys information about alcohol and alcohol-related problems, teaches decision-making skills or attempts to "clarify values") are less clear. However, teaching and counselling by peers (rather than adults) is thought to increase impact. One recent United States review argues that school programmes should focus on current alcohol problems of young drinkers (for example, traffic accidents, fights, diminished school performance) rather than trying to shape drinking practices over a lifetime (Moore & Gerstein). This would be consistent with findings that efforts to prevent onset of smoking among young people are "most successful" when they emphasize "social and immediate consequences of smoking rather than long-term health consequences" (USDHHS). There have also been promising initial results from experimental efforts to teach children skills for recognizing and resisting "social pressures" toward tobacco, alcohol and drug use.

The cumulative effect of "forces that alert, motivate, instruct, and maintain changes in public attitudes and practices" (Farquhar et al.) may well be substantial, especially when they are sustained and highly visible over the course of a generation or more.

This experience suggests that, over time, sustained public education by a wide range of public and private organizations might, for example, reduce social pressures to drink, sharply discourage drunkenness and drinking in high-risk situations, and offer support to individuals who wish to drink little, if at all.

4.2.2 Education of health professionals and other primary health care workers

Education and training of persons who provide health care might be expected to prevent or reduce a variety of specific alcohol-related problems - among them, the following:

- adverse alcohol-drug interactions;

- combined dependence on alcohol and drugs;

- adverse effects of alcohol consumption during pregnancy; and

- widespread alcohol-related problems, including the alcohol dependence syndrome, among health professionals themselves.

Early studies of the attitudes of physicians and other health professionals toward alcoholics found these attitudes "to be pervasively negative and to limit diagnostic and therapeutic abilities" (Fisher et al.). Attempts to change attitudes were not generally successful, perhaps because "many of the programs were based on the assumption that attitudes would be favourably influenced merely by an increase in knowledge" (Ewan & Whaite).

More recent studies suggest that attitudes can be improved by training which emphasizes clinical problems and provides considerable time for small group discussion; opportunities to meet recovering alcoholics and visit alcoholism treatment programmes are also considered helpful. One study, concurring that "formal education is of limited value in changing attitudes", indicates "these deficiencies may be overcome if courses are combined with opportunities to gain support and experience" (Cartwright).

The importance of improving the attitudes of health professionals toward alcoholics is weighed differently by different observers. It is argued by some that, faced with a limited amount of time in which to teach about alcoholism (for example, to medical students), the emphasis is best placed on acknowledging and exploring negative attitudes toward alcoholism and alcohol-dependent patients; the conviction is that such efforts are "important prerequisites of positive educational outcome, particularly ... augmented clinical skills" (Grant).

4.3 Measures for which evidence of effectiveness is mixed

4.3.1 Other restrictions on the distribution of alcoholic beverages

Statistical analyses of relationships between alcohol consumption, alcohol-related problems and various measures of the physical availability of alcoholic beverages (for example, density of different types of sales outlets) have produced widely varying results.

For example, there is a "major effect on consumption and problems of intoxication" if outlets for alcoholic beverages are closed for a whole day each week (Smart).

> In 1977, State-owned stores for the off-premise sale of spirits and wines in a region of Finland were closed on Saturdays for eight months (though light and medium beer continued to be available at grocery stores). "The closure reduced public drunkenness and alcohol-related

> violence, as well as total consumption." There was no evidence of an increase in consumption of illicit alcohol (Smart).
>
> In Mexico, "in the month of December 1981, a decrease in the number of accidents, arrests, etc., occurred in one state that carried out an experiment to see if alcohol consumption would drop when sale of liquor was limited to certain hours and days of the week" (Medina-Mora).

However, individual small changes in merchandising practices, hours of sale, and type, location, and frequency of outlets are generally found to have "small or insignificant effects" on total alcohol consumption and alcohol-related problems (Smart). For example:

> In Scotland, in 1976, the law was amended to permit "licensed premises" to remain open for an extra hour in the evening on weekdays. Surveys to monitor the effects of this change found "no statistically reliable evidence of overall increase (or decrease) in [average] consumption" subsequent to the change. Furthermore, "examination of statistics of drink-related offenses known to the police provides no evidence of increased numbers as a result of the extra permitted hour's drinking and there is some evidence of a decrease possibly associated with the change. The distribution of the timing of offenses shows substantial decreases between 10 p.m. and 11 p.m. with corresponding later increases. Very similar results are found from an examination of road accident statistics" (Bruce).

4.3.2 Regulation of advertising and other promotion of alcoholic beverages

It is not known whether or to what extent advertising for alcoholic beverages influences per capita consumption of alcohol or the nature and level of alcohol-related problems.

Econometric studies (which usually consider the effects of marginal changes in advertising volume as measured by marginal changes in expenditures for advertising) usually conclude there is no significant relationship between advertising and per capita consumption. Where relationships are observed, they are generally small and often contradictory (van Iwaarden). In brief, neither the existence nor the direction of a causal link between advertising and per capita consumption has been established.

Indeed, many studies find it "just as likely that increased sales will stimulate advertising expenditures as that advertising will stimulate sales". Some note that "in a fairly stable market the advertising budget of a certain product in general is a fixed percentage of the sales volume" (van Iwaarden). And there is no lack of empirical support for the alcoholic beverage industry's argument that brand advertising simply shifts the distribution of market shares, without increasing total demand.

Other studies, however, point out that under certain conditions advertising may increase total demand - for example, when social, economic and technological forces are "favourable to the spontaneous expansion of demand" (Whitehead). For developing countries in which a large portion of the population does not presently drink alcoholic beverages, disposable income is rising (or the relative price of alcohol falling), and transportation and distribution networks developing rapidly, these findings may warrant special attention.

It should also be noted that regulation of advertising for alcoholic beverages is often seen as relevant to accomplishing purposes other than reduction of alcohol-related problems - among them, the following:

- signalling the government's conviction that alcohol consumption poses serious risks to health and social well-being;

- increasing the credibility of other governmental actions to prevent alcohol-related problems;

- creating an environment in which public education about risks associated with alcohol consumption has greater opportunity to be effective; and

- reducing the possible influence of advertising revenues on editorials and news reports about alcohol-related problems.

In addition, it is often seen as having important symbolic effects.

4.3.3 Encouraging consumption of beverages with lower alcohol content or no alcohol content at all

Sharp price differentials have been known to shift consumption from distilled spirits to beer, with consequent reductions in total alcohol consumption and in some alcohol-related problems. For example:

> In Denmark, "during World War I, the price of ... akvavit was raised from 0.9 Kronor to 11 Kronor per litre; the corresponding increase for beer was from 0.15 to 0.24 Kronor. This drastic measure reduced the rate of per capita alcohol consumption from 6.7 to 1.6 litres of absolute alcohol within two years. The decrease was mostly due to the diminished consumption of akvavit ... Denmark was thereby transformed from a primarily distilled spirits drinking country to a beer drinking country. Not only was consumption affected, but the rate of registered cases of delirium tremens declined from 27 to 2 per 100 000 inhabitants, and there was a corresponding decrease from 12 to 2 in the death rate from [chronic alcoholism]" (Bruun et al.).

The effects on alcohol consumption and alcohol-related problems of increasing the availability of non-alcoholic beverages have not been systematically evaluated. However, in some countries, alcoholic beverages are less expensive than fruit juices and soft drinks and non-alcoholic beverages (including water) are not always easily available.

Although the risks of some alcohol-related problems may be greater with the consumption of one alcoholic beverage than another, it must be remembered that consumption of low-alcohol beverages is no protection against development of alcohol-related problems; the more significant factor is total amount of alcohol consumed.

4.4 Measures for which there is virtually no evidence of effectiveness, though they seem promising

There are a number of measures which might prevent specific alcohol-related problems for which very little evidence of effectiveness currently exists, though the logical argument for their value is strong and/or efforts to date have shown promise. These include efforts: (1) to reduce alcohol-related accidents in the workplace; (2) to prevent physical and psychological problems among children whose parents are alcoholics; and (3) to modify physical and social environments so that when drinking and drunkenness do occur certain harmful consequences will not also occur.

5. Conclusions

The continuation of current trends in alcohol production and consumption has far-reaching public health implications. Awareness of these implications can create the opportunity for countries to take the action necessary to halt or reverse adverse trends. Since governments have the capacity through legislation to control the supply of alcoholic beverages and thus to influence the rates of associated health and social problems, there is an urgent need for action to be taken now in those countries where per capita consumption rates are high or where the increase in per capita consumption is particularly steep.

WHO has already conducted a review of the relative effectiveness of various policy measures designed to reduce alcohol-related problems. Looking forward, there are two targets which have been agreed on for the Eighth General Programme of Work (1990-1995) for the WHO Programme on the prevention and control of alcohol and drug abuse. They are:

(i) Policies and programmes for the prevention and control of health problems related to alcohol and drug abuse will have been incorporated into the national mental health, health and, as far as possible, development planning in at least half of the countries in each WHO Region.

(ii) Health problems related to alcohol and drug abuse will have been reduced in at least one-quarter of the affected countries in each WHO Region and the current unfavourable trends arrested in most of the other countries.

If these ambitious targets are to be achieved, it can only be through the active involvement of Member States in responding to the trends described in this report.

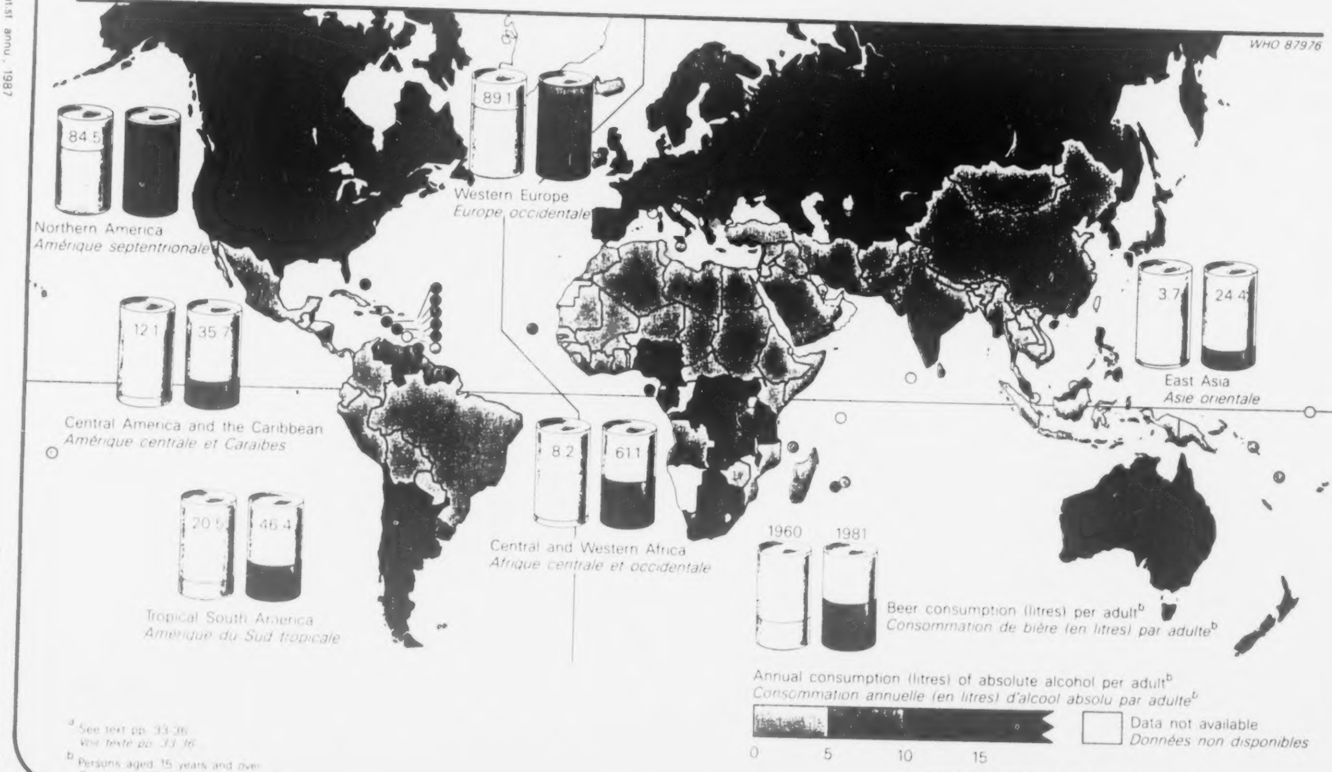
It is certainly not the function of international bodies like WHO to tell countries what they must and must not do. This is as true in the area of preventing alcohol abuse as it is in any other. What they can do is to assemble previous relevant experience from countries that have, one way or another, attempted to introduce national alcohol policies. They can then draw up guidelines from those examples and, through appropriate advice and support, assist those countries that request it. It is important to recognize, however, that some countries may well choose not to develop preventive policies at all and that others may choose to develop them without seeking advice from international organizations. In maintaining their ability to respond to a range of different requests from different countries, but mindful of the danger inherent in clinging to concepts that are rusting away through lack of use, international organizations can legitimately act in two ways. They can, through their advocacy role, encourage countries to develop their own national alcohol policies and programmes, and they can, in promoting appropriate technology, offer advice that will enable countries that do decide to act, to make their programmes as effective as possible.

All that, however, presumes a serious sustained commitment from the countries concerned. It requires both imagination and a great deal of hard work. The delicate act of balancing economic interests and public health interests is perhaps the central obstacle, but it is certainly not the only one. Cooperation among many different interest groups, within and outside government, will be necessary. Ministers with responsibility for education, agriculture, trade, employment and social affairs, among others, will need to be involved. The ministry of finance cannot but be deeply involved in the implications of any suggested policy changes. Equally, however, interested bodies outside government will have a part to play. Treatment agencies, self-help organizations and other voluntary bodies, religious institutions and teachers and parents organizations, will be likely to want to contribute to the process of policy development, and in some countries the list will be longer still. In addition, not only the alcoholic drinks industry but other industries, including catering, tourism, advertising and the media generally, will have essential contributions to make. The exclusion of any significant interested party is likely to prejudice the subsequent successful implementation of the preventive programme.

It would be naive to suppose, however, that all the different interest groups will have compatible points of view. Even within government, there will be conflicts between some ministries, as well as agreements between others; nor will the areas of agreement or disagreement be the same in every country. Within this complex interplay of different forces within countries, it is clear that the role of any international guidelines or advice is likely to be of importance in two distinct ways. Essential principles, such as the need to balance economic interests and public health interests, can be established; basic agendas can be drawn up for the area in which decisions have to be made; but the substance of these decisions is and will remain the prerogative of the countries themselves.

FIG. 1 ALCOHOL CONSUMPTION AROUND 1977 AND TRENDS IN BEER CONSUMPTION FOR SELECTED REGIONS, 1960–1981[a]

CONSOMMATION D'ALCOOL VERS 1977 ET TENDANCES DE LA CONSOMMATION DE BIÈRE DANS CERTAINES RÉGIONS, 1960–1981[a]


WHO 87976
Northern America
Amérique septentrionale
84.5
Western Europe
Europe occidentale
89.1
Central America and the Caribbean
Amérique centrale et Caraïbes
12.1
35.7
Tropical South America
Amérique du Sud tropicale
20.5
46.4
Central and Western Africa
Afrique centrale et occidentale
8.2
61.1
East Asia
Asie orientale
3.7
24.4
1960
1981
Beer consumption (litres) per adult[b]
Consommation de bière (en litres) par adulte[b]
Annual consumption (litres) of absolute alcohol per adult[b]
Consommation annuelle (en litres) d'alcool absolu par adulte[b]
0
5
10
15
Data not available
Données non disponibles

Source: Estimates based on data available to WHO
Estimations basées sur des données accessibles à l'OMS

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[a] See text pp. 33-36.
Voir texte pp. 33-36.

[b] Persons aged 15 years and over.
Personnes âgées de 15 ans et plus.

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TESTIMONY CONCERNING LEGISLATIVE REFORM TO REDUCE DRUNKEN DRIVING AND ALCOHOL RELATED TRAFFIC FATALITIES

PRESENTED TO THE U.S. SENATE COMMITTEE ON GOVERNMENT AFFAIRS
JUNE 29, 1988

by
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SUMMARY

From 1980 through 1985 considerable progress was made across the nation in reducing drunken driving and fatal crashes. Over 400 chapters of local citizen groups concerned with reducing drunken driving were formed. News media coverage about drunken driving, measured in numbers of stories, increased 50 fold from 1980 to 1984. Over 500 legislative reforms were passed. All states now have legal drinking ages of 21. Many also adopted criminal and administrative *per se* laws and instituted penalty increases for drunk driving. In 1980, 45,284 fatal crashes occurred nationally but by 1985 the total dropped 13% to 39,168 - 6,116 fewer than in 1980. Single vehicle night fatal crashes, those most likely to involve alcohol, declined even more down 20% - 3,674 fewer than in 1980. Among teenage drivers, fatal crashes declines were steeper. Fatal crashes were down 26% and single vehicle night fatal creshes were down 34%.

However, the number of new citizen groups established and numbers of media stories began to decline after 1984, and in 1986 after several years of decline, fatal crashes rose 5%, and single vehicle night fatal crashes rose 7%, up 1,060 from 1985. Among teenage drivers the increase in single vehicle night fatal crashes was higher, up 17%. Legal changes, while helpful in reducing drunk driving crashes, cannot by themselves achieve optimal long term declines.

To sustain the progress of the early 1980's we need to:

- Refocus community and media attention on the drunken driving problem.
- Increase police enforcement and public support for enforcement of our drunk driving laws.
- Heighten educational and enforcement efforts that target risky traffic behaviors more common among drunk drivers particularly speeding, and failure to wear safety belts.
- Develop educational efforts aimed at all segments of our communities to increase informal social pressure to discourage drunken driving and riding in vehicles with drunk drivers.

Traffic crashes remain the leading cause of death among persons age 1 to 34 and 52% of the 46,050 traffic fatalities in 1986 involved a driver or pedestrian who had been drinking. Without renewed attention to the problems posed by drunken driving, we may be unable to sustain the dramatic progress of the early 1980's.

INTRODUCTION

During the early 1980's the United States experienced unprecedented concern and legislative activity about drunken driving. At the same time there were remarkable declines in drunk driving and fatal traffic crashes involving alcohol. But, there are warning signs that public concern and fatal crash declines could fade. I would like to review the experience of the early 1980's with this committee and propose ways to avoid a resurgence of drunk driving and alcohol related fatal crashes.

Progress 1980-1985

Between 1980 and 1985 there was a tremendous ground swell of public concern about the drunken driving problem, and for good reason. Traffic crashes are the leading cause of death among our nation's youth, age 1 to 34.[1] Fifty-two percent, 13,987, of the 46,050 traffic fatalities recorded in 1986 involved a driver who had been drinking.[2] Drunken drivers not only place themselves at greater risk of crash involvement, but 20-40% of the people killed in drunk driving crashes are persons other than the drunk driver: passengers, pedestrians or drivers of other vehicles.

During the early 1980's citizens across the country started to demand an end to this unnecessary waste of human life. From 1980 to 1985 over 400 local chapters of citizen groups, such as MADD and RID, concerned with drunken driving were founded and news stories about the problem increased 50 fold.[3]

Legislative changes were made during the same year to reduce fatal crashes involving drunk drivers.[4] A minimum drinking age of 21 became the standard nationwide. Over 40 states adopted criminal *per se* legislation, laws making it illegal *per se* to drive with a blood alcohol level above .10 (4 to 5 drinks on an empty stomach - 7 to 8 hours after eating). Almost half of the U.S. states passed administrative per se laws that permitted licenses of suspected drunk drivers to be held from the time of arrest until their trials. In addition many states heightened the penalties for drunk driving: increasing fines, license suspension and imposing jail sentences usually on repeat offenders and those involved in injury or fatal crashes.[5]

From 1980 to 1985 when the media attention, community organization and legislation activity crescendoed nationwide, fatal crashes declined 13% from 45,284 in 1980 to 39,168 in 1985. Single vehicle night fatal crashes, those most likely to involve alcohol, declined even more, down 20% from 18,277 to 14,603. Among teenage drivers (the high risk age 15-19 group) the declines were even more dramatic. Single vehicle night fatal crashes declined 34% with 2,497 fewer in 1985 than 1980.[6,7]

These reductions were dramatic and occurred for many reasons. First, the laws themselves produced positive beneficial effects. Studies of drinking age increases revealed that while effects were variable from state to state, states raising their drinking ages typically achieved 10-15% declines in night fatal crashes in targeted age groups relative to states that did not.[8,9,10,11]

A national analysis from 1978-1985 recently completed by the Insurance Institute for Highway Safety indicated administrative per se laws, on average reduced night fatal crashes 9% relative to states that did not pass such legislation while criminal per se laws and increased penalties were each accompanied by 6% declines in night fatal crashes relative to states that did not pass such laws. While most states have criminal per se laws only half have administrative per se laws. The Institute estimated that if all states passed such laws, 2,600 fatal crashes could be avoided annually.[12]

Police enforcement of drunk driving laws and court conviction rates also increased in numerous states.

Perhaps equally important as these formal legal countermeasures was the emergence of informal social pressure that private citizens exerted on each other not to drive drunk. Annual surveys we have conducted in my own state, Massachusetts, from 1981-1985 revealed that the proportion of drivers who said they wouldn't care at all if their best friends found out that they'd been arrested for drunk driving declined from 25% to 12%.[13] During the same time frame the proportion of drivers who reported driving after 5+ drinks in the past month declined from 18% to 6% and Massachusetts experienced marked fatal crash declines comparable to the national trends.

Warning Signs That the Progress May Fade

Despite the progress, however, we can never be complacent. International experience in Great Britain and several other countries (Figure 1) (summarized by H. Lawrence Ross in this book "Deterring the Drunk Driver: Legal Policy and Social Control")[1] indicates that fatal crash declines after the passage of drunk driving laws are usually temporary as public discussion of the problem diminishes and people become aware that the chances of being caught by the police are really quite low.

Data suggest that this may be occurring in the U.S. The numbers of new citizen groups formed that were concerned with drunk driving peaked in 1983 (Figure 2).[3] News and magazine stories about drunk driving declined sharply after 1984.[7] (Figure 3) After several years of decline single vehicle night fatal crashes rose 7% in 1986 while other fatal crashes rose only 3% (Figure 4). Among teen drivers the increase was even greater (Figure 5); they experienced a 17% increase in single vehicle night fatal crashes compared to 6% of other fatal crashes. Our projections closely parallel estimates from the U.S. Department of Transportation which say overall alcohol related fatalities increased 7% and among teenage drivers the increase was 14% in 1986 compared to 1985.[2] Every year new cohorts of drivers enter the high risk teenage driving pool. It is quite possible that today's teenage drivers were not paying attention to all the media attention and public discussion of drunk driving that occurred during the early 1980's and therefore have been exposed to less discussion of the problem than were teen drivers in the early 1980's.

Can Anything Be Done to Sustain the Fatal Crash Declines of the Early 1980's?

I do not believe it is inevitable that fatal crash declines following drunk driving laws must fade. Several steps can be taken to regain national momentum in reducing drunk driving fatal crashes.

First, we must redouble our efforts to keep the public's attention focused on this issue through local community organization and media attention to the problem. Hearings like those you are holding today are a crucial part of this process. I applaud this effort and hope you will hold future hearings on the same topics.

As I mentioned, today's teenage drivers may not have been paying attention to the media attention and public discussion about drunk driving in the early 1980's. We must continue to heighten awareness of these problems among this group. School-based peer led education programs have been successful in reducing other health compromising behaviors[14] among adolescents and may hold particular promise in the drunk driving area. But they must be accompanied by general programs aimed at all age groups so that teenagers will not be given the erroneous impression that adults believe it is unsafe for teens to drink and drive, but this is an acceptable risk for adults. Such an impression would only convey the message that drunk driving, like smoking, is a symbol of adult status and might make driving drunk a behavior teens engage in to appear like adults.

Second, police enforcement of the drunken driving problem must be increased. In all the New England states we have studied, even though a majority of drivers believe arrested drunk drivers will be convicted and punished, only one-quarter of drivers believe it is very likely that drunk drivers will be stopped by the police.[7] In those surveys we found that only 3 arrests for drunk driving occurred for every 1,000 drunk driving trips reported by survey respondents (Table 1). We must ask ourselves if 3 arrests per 1,000 drunk driving trips is an acceptable level of enforcement and can serve as a credible deterrent to drunk driving.

Increasing police enforcement will not only require expenditure of considerable financial resources to mobilize more officers at high risk times and locations, namely weekend nights on high speed roads, it will also require cultivation of public support for more enforcement. Despite the low levels of arrest, a sizable minority of drivers in New England believe police enforcement around drunken driving is adequate. Efforts are needed to make the public aware that more enforcement would be helpful and that appropriately conducted, active police enforcement is a public service not an infringement of personal liberty.

Third, we must not shift attention away from related risky traffic behavior more prevalent among drunk drivers. As a group, drunk drivers are much more likely to engage in a variety of risky traffic behaviors. In our studies, New England persons who reported driving after 5+ drinks in the past month, when compared to those who never did so, were:

- ten times more likely to drive after marijuana and other drug use;
- twice as likely to report speeding 20+ miles over the limit and running red lights in the previous week;
- one-quarter as likely to wear safety belts;
- four times more likely to be given a traffic ticket for violations other than drunk driving;
- and five times more likely to have been involved in a crash resulting in an injury in the past year (Table 2).

Our own intensive analysis of Maine's 1981 comprehensive drunk driving laws (criminal per se law with administrative per se provisions) revealed that sharp initial fatal crash declines following that law were compromised by a shift in police enforcement, after the law, away from speeding enforcement.[13] State police arrests for speeding declined from 31,000, the year the law passed, to 19,000, two years later, during which time the proportion of drivers traveling 65+ miles per hour on 55 posted roads almost doubled. Night fatal crashes which had declined 33% the year after the law was passed returned to the pre-law level by the third post-law year. When Maine officials initiated a speeding crackdown in January 1985, in response, fatal crashes again began to decline 16% in 1985 relative to 1984. (Figure 6)

Drunken drivers because of their poor sensory motor coordination and reaction time may be particularly vulnerable to crashes at high speed. Maine's experience unfortunately may be a precursor of the national experience. In 1987 38 states raised their speed limits in rural interstates and a U.S. DOT report released last month on the first nine months of those changes indicates fatalities increased 23% on rural interstate roads while they declined 13% on urban interstates and 5% on other roads in those states where speed limits were not raised.[14] How many of those who advocated raising the speed limits appreciate the greatly increased risk that higher speed poses for drunk drivers and others who happen to be on the same roadways with drunk drivers? It makes no sense to advocate tougher drunk driving laws and enforcement and at the same time to relax our speed limits.

Fourth, I recommend the development of programs aimed at increasing informal social pressures not to drive drunk. Too often our response to traffic problems is to delegate them to the police. An effective but less often pursued deterrent to drunk driving is social disapproval by one's peers. In many states that passed new drunk driving laws during the 1980's fatal crash declines began prior to the passage of the laws as the public debated the problems posed by drunk drivers.[13]

The importance of social pressure in mediating risky behavior has been demonstrated in other areas most particularly smoking, diet, and exercise. We need to understand and emphasize the role of social norms in effecting drunk driving and related risky traffic behaviors.

Substantial progress could be made in reducing drunk driving fatalities by encouraging people not to ride with intoxicated drivers. Every year approximately 4,000 persons are killed in drunk driving crashes who are passengers riding with the drunk driver. Getting into a car with a drunk driver provides tacit acceptance of his/her behavior. Every effort must be make to mobilize people not to ride with intoxicated drivers and to provide them with alternative transportation so that they won't have to get into a car with an intoxicated driver.

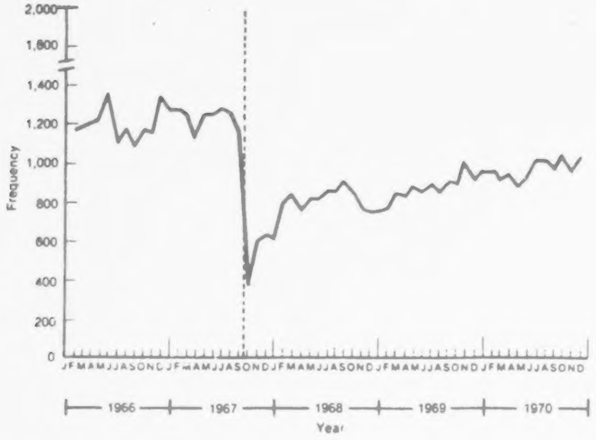
Results from experiments in changing cardiovascular risk factors may have applicability in the drunk driving area. While community intervention studies of programs to increase police enforcement and public awareness of enforcement have achieved short term declines in drunk driving,[16,17,18] community-wide, multi-strategy interventions for changing heart disease risk factor behaviors (e.g. smoking, diet, alcohol consumption and sedentary life-style) have been demonstrated to have longer term effects on those behaviors. Large-scale controlled studies in Finland, California, and most recently in Minnesota examined programs that target not only high risk groups, but also direct interventions at the total community via the media, schools, workplaces and community organizations.[19,20,21] Significant positive behavior changes were reported across socio-economic and risk factor strata in the target communities relative to comparison communities. These studies show the potential of sustaining behavior change by developing a community consensus about a problem. Establishment of this kind of program requires substantial commitment of time, energy and financial resources not only from federal and state governments but also grassroots public and private sector support from local communities. Whether such programs can successfully achieve long term change in social norms and reduce traffic behaviors like drunk driving warrants careful study.

Finally, I would like to mention that our efforts to reduce the numbers of alcohol related traffic crashes and deaths on our highways can involve many additional strategies (Table 3) which I have not had time to detail, but no doubt will be discussed by others providing testimony. Taxes on alcohol and changes in zoning and licensing practices can make alcohol less accessible to high risk drivers. Night curfews for adolescent drivers, increases in driving ages, increases in automobile and gasoline taxes, expansion of public transportation and alternative transportation programs can make automobiles less accessible or less necessary for young high risk drivers. Improvements in vehicle and roadway design such as airbags, protective barriers and improved signs can help reduce the likelihood of crashes and injurious consequences for drunk drivers and non-drinking persons they crash into. Improvements in enforcement of existing laws such as minimal legal drinking ages, and implementation of social host liability for person who serve or purchase alcohol for minors all warrant consideration.

CONCLUSION

Legislative reforms such as raising the legal drinking age, criminal and administrative *per se* laws and penalty increases as well as, public discussion about drunk driving and its dangers have all helped reduce drunk driving across the nation. Progress has been made and further progress can be made in reducing alcohol related traffic deaths and injuries. But, we should not be lulled into complacency because efforts in the early 1980's produced fatal crash declines. The drunk driving problem will quickly re-emerge if we do not continually engage in efforts to keep public attention focused on this issue and develop a strong social consensus that driving after heavy drinking is an unacceptable behavior that poses a threat to drunk drivers and others as well.

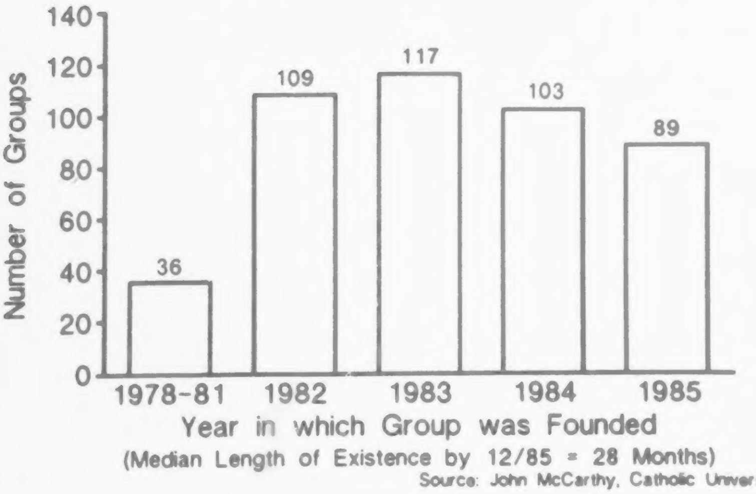
Figure 1
British Road Safety Act



Source: Ross 1973, p. 33. Copyright by The University of Chicago Press. Reprinted with permission.

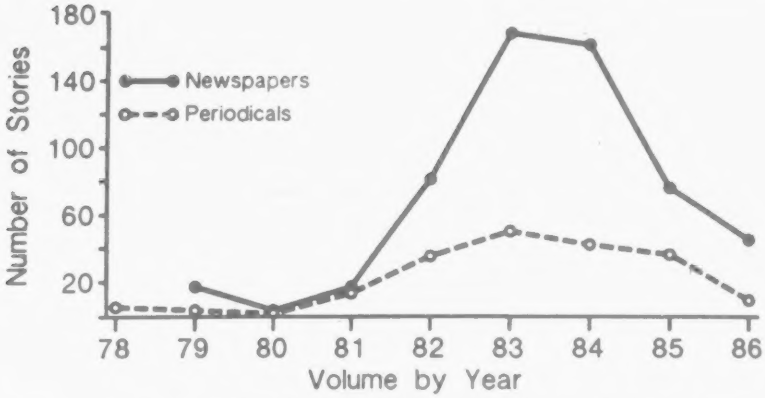
Fatalities and Serious Injuries in the United Kingdom, Combined for Friday Nights, 10 P.M. to Midnight; Saturday Mornings, Midnight to 4 A.M.; Saturday Nights, 10 P.M. to Midnight; and Sunday Mornings, Midnight to 4 A.M.; Corrected for Weekend Days per Month and with Seasonal Variations Removed

Figure 2
Number of Anti-Drunk Driving Groups Founded
by Year



Source: John McCarthy, Catholic University

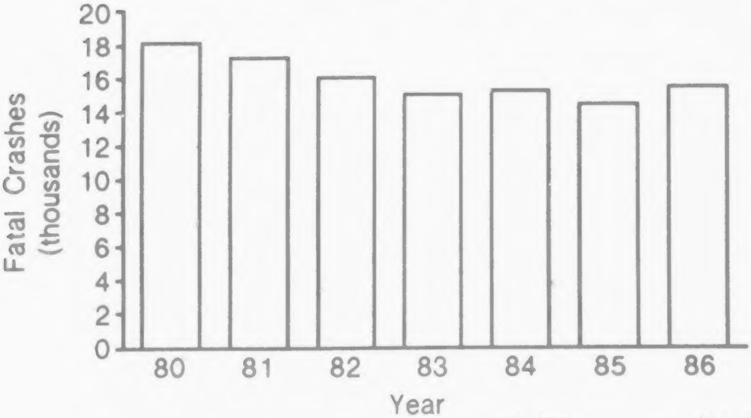
Figure 3
Volume of National Newspaper and Periodical Coverage of Drunk Driving by Year



Newspaper Volume based on count of stories in the National Newspaper Index. Includes: N.Y. Times; L.A. Times, Wall St. Journal, Washington Post
Periodical Volume based on Magazine Index

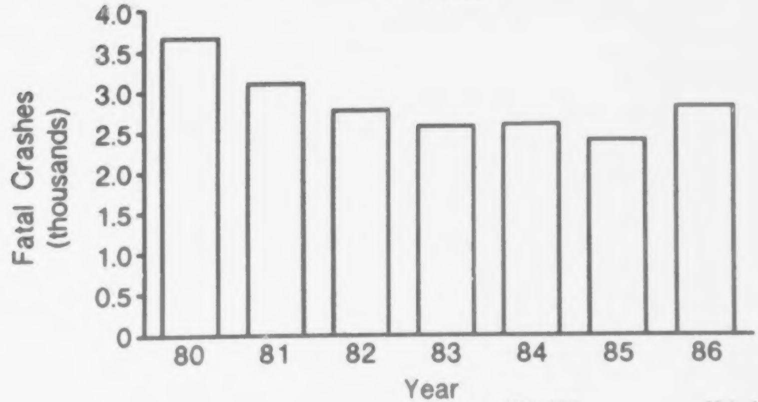
Source: John McCarthy, Catholic University

Figure 4
SVN Fatal Crashes Nationwide, All Ages
1980-1986



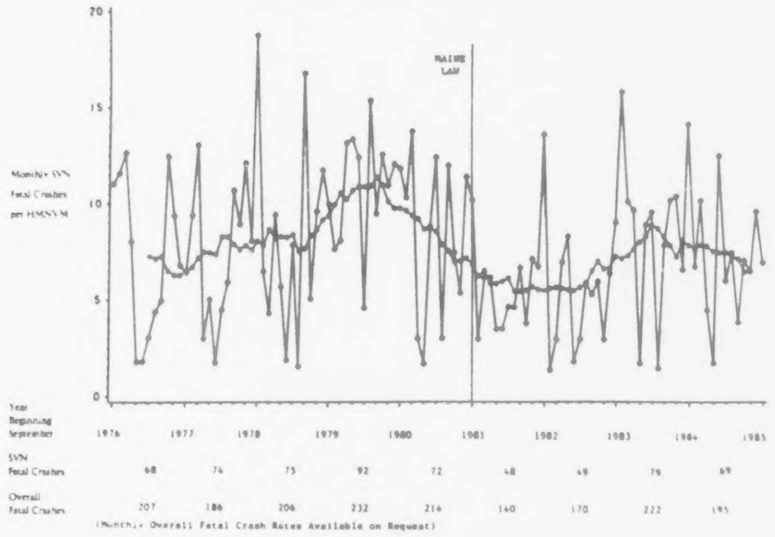
	'80-'85		'85-'86	
SVN Crashes	3,674	↓ 20%	1,894	↑ 7%
Other Crashes	2,442	↓ 9%	834	↑ 3%

Figure 5
Teen SVN Fatal Crashes Nationwide
1980-1986



	'80-'85		'85-'86	
SVN Crashes	2,497	↓ 34%	702	↑ 17%
Other Crashes	1,212	↓ 20%	290	↑ 6%

Figure 6
Maine Fatal Single-Vehicle Nighttime (SVN) Crashes per Nighttime Vehicle Miles Traveled and Annual Fatal and SVN Fatal Crash Frequencies, 1976-85



Note: Smoothed curve is a 12-month moving average

Table 1
Drunk Driving Enforcement in New England
1982-1985

	1982 N=3,314	1983 N=3,340	1984 N=3,248	1985 N=3,282
Stops After Drinking/ 1,000 D.D. Trips	11.1	16.1	21.1	33.1
Took Breath Test/ 1,000 D.D. Trips	2.5	4.6	3.4	5.9
Tickets for DWI/ 1,000 D.D. Trips	1.0	2.0	2.0	2.8
Accidents After Drinking/ 1,000 D.D. Trips	2.1	2.5	3.0	2.1

D.D. Trip = Trip after 5+ Drinks

Table 2
Survey of Adult Drivers in Massachusetts
1985,1986

Characteristics of Persons
Who Drive After Heavy Drinking (5+ Drinks)

	Times Drove in Past Month After Heavy Drinking		
	0 N=1758	1-3 N=88	4+ N=30
Past Month			
Drove After Marijuana use	4%	18%	41%
Other Drugs	3	4	27
Wore Seat Belts 90% of the times	43	22	11
Past Week			
Ran a Red Light	8	12	18
Speed 20 MPH Over Limit	15	39	32
Past Year			
Driving Violation Other than Drunk Driving	11	29	40
Driver in Crash	9	19	19
Driver in Crash Resulting in Injury	1	2	5
Strongly Oppose			
Seat Belt Law	18	26	26
Safe Roads Act (Drunk Driving Law)	9	17	70
55 MPH Speed Limit	11	12	35

TABLE 3
STRATEGIES TO REDUCE TRAFFIC FATALITIES AND INJURIES ASSOCIATED WITH DRUNK DRIVING

MAKE ALCOHOL LESS ACCESSIBLE

- Raise drinking age
- Higher taxes
- Zoning restrictions on sales
- Happy hour laws

MAKE VEHICLES LESS ACCESSIBLE OR NECESSARY

- Raise taxes on vehicles
- Increase public transportation
- Raise driving age
- Curfews
- Interlock system for driver

MAKE DRIVING ENVIRONMENT SAFER

- Make crashworthy vehicles
    - airbags
    - automatic seat belts
- Reduce speeds
- Widen lanes, better marking, banking
- Fewer two-lane, high speed roads
- Seat belt laws
- Improve EMS and medical care

DISSUADE DRIVERS FROM DRINKING

- Education
- General deterrence
- Increased fines
- Greater police enforcement
- Longer license suspension
- Increase convictions

SPECIFIC DETERRENCE

- Treatment and reduction
- License revocation, etc..

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Testimony of Philip J. Cook, Professor of Public Policy and Economics, Duke University, to be presented on [redacted]e 29, 1988 before the U.S. Senate Committee on Governmental Affairs

Drinking three ounces of beverage alcohol will cause substantial impairment in most people. The federal excise tax on this quantity of alcohol depends on the type of beverage in which it is consumed; 58.5 cents for liquor (6 ounces of 100 proof), 16 cents for beer (a 6-pack), and three cents for wine (a fifth). These tax rates are very low by historical standards. Increasing these rates would increase the alcoholic beverage prices, reduce consumption, and reduce the prevalence of alcohol abuse.

Inflation and the Erosion of the Excise Tax

The prices of alcoholic beverages have been declining rapidly in recent years in comparison with prices of other consumer items. Consumer Price Index statistics indicate that between 1967 and 1987 the real price of all alcoholic beverages declined 28 percent. Distilled spirits have led the way with a 50 percent fall in price. The results of econometric and epidemiologic studies show that reductions in price have the effect of promoting alcohol consumption and increasing the incidence of alcohol-related problems.

The fact that liquor prices are currently one-half of the 1967 level, and beer and wine prices have also declined, can be attributed in part to Congressional inaction with respect to federal excise taxes on alcoholic beverages. Current federal excise tax rates were set in 1951 but have been largely repealed by inflation since then. If the federal tax had been indexed to the Consumer Price Index in 1967, the average cost of a fifth of liquor (86 proof) would currently be about $3.70 higher. Indexing the beer tax would have had a smaller but still substantial effect on beer prices. It can be argued that the failure of Congress to increase taxes in step with inflation constitutes the most important feature of federal government policy in alcohol abuse prevention during the past 20 years.

Alcohol Taxes and the Rate of Alcohol Abuse

Alcohol abuse is a major public health problem. There are roughly 100,000 alcohol-related deaths each year (Ravenholt, 1984). Alcohol-related morbidity and injuries impose a considerable burden on the health care system. A recent estimate (Schifrin, 1983) of health care costs stemming from alcohol-related problems is $20 billion for 1979--about 10 percent of total health care expenditures for that year. The cost of absenteeism and reduced productivity associated with employee drinking and premature death is even greater--roughly $78 billion in 1979 (Schifrin, 1983).

For alcohol taxes to be an effective policy instrument for reducing these and other costs associated with alcohol abuse, it must be true that higher alcohol prices reduce the prevalence of chronic heavy drinking and the incidence of drunkeness. An increase in tax rates on liquor, wine, and beer results in an increase in the average prices of these commodities and a reduction in alcohol consumption from these sources. (More precisely, consumption is less than it would have been without the tax increase.) This result has been documented and measured using data from the United States and Canada (Johnson and Oksanen, 1977; Ornstein and Hanssens, 1981; Cook and Tauchen, 1982). More important and controversial is the question of how taxes and prices influence the consumption levels of the heaviest drinkers. It is logically possible that average consumption would fall as a result of a tax increase solely due to its effect on moderate drinkers; the heaviest drinkers may be immune to economic incentives. An argument supporting this possibility can be stated by a chain of hypothetical propositions: (1) a large portion of the heaviest drinkers are alcoholics, in the sense that they are addicted to alcohol; (2) alcohol addicts will drink something like the biological maximum every day, practically regardless of the cost of obtaining their drinks; (3) therefore, it must be the more moderate drinkers who adapt their drinking practices to the price of alcoholic beverages.

This sort of argument may seem plausible to many. In reply, an economist would point out that a price increase has a greater economic impact on an alcoholic--who may already be spending a third or more of his or her income on alcohol--than on a moderate drinker, and that ordinarily this greater impact would be expected to yield, if anything, a greater response in consumption behavior. Furthermore, there is considerable clinical evidence that alcohol consumption by alcoholics is responsive to experimental manipulations of the costs of taking a drink (Mello, 1972; Nathan and Lisman, 1976). In any event, this issue can be better resolved through careful empirical analysis than through unsupported generalizations about the behavior in question.

The Effect of Alcohol Taxes on Cirrhosis Mortality

Statistics on the prevalence of chronic heavy drinking are not widely available. However, there is a widely accepted proxy measure--the rate of deaths due to cirrhosis of the liver. These death reates have provided the basis for nearly all estimates of alcoholism prevalence rates (Seeley, 1960).

Most people who die of liver cirrhosis, especially after age 30, exhibit a history of chronic intense drinking: Schmidt (1977) found that 80 percent of all cirrhosis deaths in Ontario in 1974 were alcohol-related. The typical victim of alcohol-related cirrhosis has consumed an enormous amount of alcohol: Lelbach (1974) estimates that a primarily healthy, 150-pound person who drinks roughly 21 ounces of 86 proof liquor every day for about 20 years has a 50 percent chance of contracting liver cirrhosis. Thus, for any one individual, there tends to be a long lag between the onset of heavy drinking and the prospect of death from liver cirrhosis. The cirrhosis mortality rate is therefore not a direct indicator of the current fraction of alcoholics in a population, but does give a good indication of the fraction that has been drinking heavily for two or more decades. It should be kept in mind that the cirrhosis mortality rate is of interest in its own right, in addition to being a proxy for the prevalence of alcoholism. Cirrhosis is among the leading causes of death in the United States.

Using this statistical indicator of the prevalence of chronic excess consumption, it is possible to explore the relationship between alcohol taxes and excess drinking. My first study of this relationship (Cook, 1981) was based on annual observations of 30 states for the 15 year period from 1960 to 1974. During this period there were 38 instances in which one of these states increased its liquor tax by a substantial amount (more than $.24 per proof gallon). I viewed each of these tax increases as a test case in a sort of "natural experiment." For each of these cases, the percentage change in the state's cirrhosis mortality rate was calculated: the test statistic was defined as the mortality rate after the tax increase, minus the mortality rate before the tax increase, divided by the contemporaneous mortality rate. The control groups for each of these test cases were the other states in the corresponding years. The result was that states that raised their liquor tax typically had a greater reduction (or smaller increase) in cirrhosis mortality than other states in the corresponding year (see the Table). Indeed, 63 percent of all test cases were in the upper half of the distribution with respect to the test statistic--a result that would occur by chance alone with probability of only 7.2%. This result is fairly strong evidence that the tax increase reduced the cirrhosis mortality rate, at least in the short run.

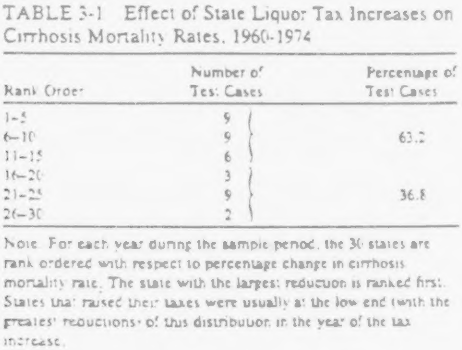

TABLE 3-1 Effect of State Liquor Tax Increases on Cirrhosis Mortality Rates, 1960-1974

Rank Order	Number of Test Cases	Percentage of Test Cases
1–5	9	63.2
6–10	9	
11–15	6	
16–20	3	36.8
21–25	9	
26–30	2	

Note. For each year during the sample period, the 30 states are rank ordered with respect to percentage change in cirrhosis mortality rate. The state with the largest reduction is ranked first. States that raised their taxes were usually at the low end (with the greatest reductions) of this distribution in the year of the tax increase.

My quasi-experimental approach to studying the effect of liquor taxes on heavy drinkers has the virtues of simplicity and ease of interpretation. It does not generate a precise estimate of the magnitude of the effect in question, however. Primarily for this reason I undertook a second study (Cook and Tauchen, 1982), which applied an estimation technique (analysis of covariance estimated by generalized least squares regression) to annual data from the same 30 states for the period 1962-1977. Before undertaking this task, we refined the annual state-level cirrhosis mortality data: our variable was the age-adjusted mortality rate for state residents ages 30 and over. Our principal result can be stated this way: other things being equal, a $1 per proof gallon increase in a state's liquor tax will reduce the state's cirrhosis mortality rate by 1.5 percent in the short run, and more in the long run. (The tax variable in the regression was adjusted for inflation, as measured by the Consumer Price Index. The statement of our results given here is converted to 1987 dollars.) Our parameter estimate suggests further that the tax effect is far from trivial--according to this estimate, a doubling of the U.S. federal liquor tax would reduce the nation's cirrhosis mortality rate by a figure in the neighborhood of 20 percent.

Given the normally long lag between the onset of heavy drinking and death from cirrhosis, it may not be obvious how an increase in the liquor tax could cause an immediate reduction in cirrhosis mortality. The reason is that the cirrhotic process is interruptible--if at any time an alcoholic should stop drinking, his or her liver would cease to deteriorate. If the rate of consumption slows, then the deterioration process also slows. At any one time, there is a reservoir of people who are within one year of death from cirrhosis at their current rate of consumption. If some of them reduce their consumption in response to a tax increase, then not all of them will die in that year--i.e. the mortality rate will decline in the first year. What about the trend in mortality over the long run? The mortality rate will gradually decline after the initial drop, as the size of the reservoir gradually shrinks. The total effect of the tax increase will not be realized for many years, but clearly the ultimate reduction in mortality rates due to such an increase will exceed the initial reduction. Thus, our figures underestimate the full effect.

In conclusion, there is considerable statistical evidence that a liquor tax increase causes an immediate and substantial reduction in cirrhosis mortality. If cirrhosis mortality rates are a reliable indicator of the prevalence of alcoholism, then it can be inferred that alcoholics' drinking habits are quite sensitive to the price of liquor.

The Effect of Alcohol Taxes on Auto Fatalities

There is also some direct evidence that accident rates are responsive to changes in the liquor tax. I tested the effect of state liquor tax increases on the auto fatality rate in my 1981 paper, using the same sample and technique as those in the cirrhosis study. Between 1960 and 1974, most of the states (25 of 38) that increased their liquor tax subsequently experienced a below-average change in auto fatality rates relative to states that did not increase their tax.

A recent study by Henry Saffer and Michael Grossman of the National Bureau of Economic Research provides persuasive evidence that the highway fatality rate for youths (age 15-24) is quite sensitive to the excise tax rate on beer. They focused their study on beer because it is the alcoholic beverage of choice for youthful drinkers. Based on a sophisticated analysis of fatality data for 48 states over the period 1975-81, Saffer and Grossman are able to estimate the effects of alternative federal excise tax policies. For example, they report that if the federal tax on beer had been indexed to inflation since 1951, then the fatality rate for 18- to 20-year-olds would have been reduced by 15 percent during the period 1975-81. The other age groups would also have enjoyed substantial reductions in highway fatalities.

Conclusion on Public Health Effects

Available evidence suggests that increases in alcoholic beverage taxes cause reductions in per capita consumption, consumption by chronic heavy drinkers, and the incidence of drunken driving. It seems safe to conclude that the sharp decline in alcohol prices during the last 20 years has exacerbated alcohol-related public health problems. Fortunately there appear to have been countervailing forces at work during this period, such as increased emphasis in the popular culture on health and fitness, that have prevented a large increase in drinking from occurring. Indeed, adult per capita consumption has changed very little since 1970. If alcohol prices had kept pace with inflation, the per capita consumption would probably have declined substantially during this period.

Equity Considerations in Alcoholic Beverage Taxation

Alcohol control policies, including taxation, have been criticized by some as excessively blunt instruments, reducing the enjoyment of the many for the sake of curtailing the alcohol-related problems suffered by the relatively few. In the imagery of Gusfield (1976:275), these policies fall "like sober rain from heaven upon the problem and problem-free drinkers alike." There are two comments to be made in response to this critique.

First, much of the social cost of excess drinking also falls on "the problem and problem-free drinkers alike," as well as the abstainers. Our government social insurance tax rates and private auto and health insurance premiums reflect, in part, the costly consequences of alcohol abuse. The drunk driver puts all of us at increased risk of an injury or death on the highway. Thus, it can be argued that an effective alcohol control measure will indirectly benefit the problem-free drinkers (as well as those who abstain) by reducing the collective costs generated by problem drinking.

Second, the direct costs of alcohol control measures such as taxation are more or less proportional to the amount of alcohol an individual consumes--the "sober rain" falls on all drinkers, but with much greater intensity on the chronic heavy drinkers than on others. In the United States it is estimated that the heaviest-drinking 9.3 percent of the adult population consumes about 65 percent of all beverage alcohol sold each year (NIAAA, 1982). To the extent that alcohol taxes are proportional to ethanol content, then, this top group of drinkers will also pay 65 percent of the taxes. Thus, the relatively small group of drinkers who have the highest incidence of alcohol-related problems also pays the bulk of the alcohol taxes.

To summarize, alcohol taxes, if effective in reducing the costly consequences of excess consumption, reduce the burden alcohol imposes on society at large. Furthermore, whether or not alcohol taxes are effective in reducing the costly consequences of excess consumption, they have the characteristic of exacting payment in proportion to consumption and hence (very roughly) in proportion to the social costs generated by their consumption. If we believe that the drinker should pay (at least in an actuarial sense) for the social costs related to his or her drinking, then the excise tax on alcohol is an appropriate mechanism.

A second equity issue concerns the burden imposed on poor households by alcohol taxes. Such taxes are of course not adjusted to the household's ability to pay (as is the income tax), and by a traditional measure alcohol taxes appear slightly regressive (Sammartino, 1988). However, it is certainly possible that an increase in alcohol taxes will actually prove beneficial to the children of the heavy drinkers in poor families. For example, if a household's demand for alcoholic beverages is elastic (price elasticity greater than 1.0), an increase in price will cause a reduction in total expenditures on drinking thereby leaving more money for other household expenditures. Surely poor households vary considerably with respect to price elasticity of demand. However, the available evidence suggests that the average household's demand for liquor is quite elastic; furthermore, poor households would tend to be more elastic than higher income households. Therefore, for some fraction of poor households, an increase in alcohol tax rates would reduce expenditures on alcoholic beverages. And, it is quite possible that a tax-induced reduction in consumption by heavy-drinking household heads may benefit other family members insofar as reduced drinking yields improved health and higher earnings.

Conclusion

The decline in the real value of the U.S. federal excise taxes on alcoholic beverages has had the effect of increasing the prevalence of alcoholism and its attendant costs. Raising the excise tax would be a rather well-targeted response to the social burden that heavy drinkers as a group impose on the rest of society. There are a number of alternatives for reducing the U.S. budget deficit. Few of them have the substantial beneficial side effects that would result from raising the alcohol excise tax rates.

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PUBLIC INTEREST

HEALTH AND SAFETY WARNING LABELS ON ALCOHOLIC BEVERAGE CONTAINERS

Statement of
Patricia Taylor

The Center for Science in the Public Interest

before the

Committee on Governmental Affairs
United States Senate

September 27, 1988

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EXECUTIVE DIRECTOR: MICHAEL F. JACOBSON, Ph.D.

Senator Glenn, on behalf of the Center for Science in the Public Interest and its 100,000 members, I would like to thank you and your Committee for holding these long overdue hearings. My name is Pat Taylor and I am Director of the Alcohol Policies Project of the Center for Science in the Public Interest, a non-profit health organization that was founded in 1971 and has been working since 1980 to prevent and reduce alcohol-related problems. In addition to our work on health and safety warning labels, we coordinate the National Alcohol Tax Coalition and coordinated Project SMART, a campaign to require equal time on television and radio for health and safety messages about alcohol.

As you have heard from other witnesses, alcohol-related problems are taking a tremendous toll on our society -- they affect Americans in all walks of life, with little regard for economic, social, or cultural background. As a society, we are paying a dear financial price for alcohol problems. This is at a time when scarce resources have meant drastic reductions in domestic programs and left new initiatives in the planning stages. We look forward to working with you to develop ways to reduce alcohol-related tragedies and costs.

Just as alcohol is the neglected step-child in the national debate on how best to wage a War on Drugs, prevention policies are the black sheep of the federal alcohol effort. We welcome your interest in this area and hope that after your review of the testimony, you will conclude that we must act to implement prevention policies.

I have been asked to testify about warning labels, a simple, straightforward way to inform consumers about the health and safety risks of alcoholic beverages. The history of attempts to require these labels is not so simple.

History of federal action on health and safety warning labels

In 1977, Food and Drug Administration (FDA) Commissioner Donald Kennedy informed the Treasury Department's Bureau of Alcohol, Tobacco and Firearms (BATF) that he thought health warning labels were needed to inform consumers about the risks of drinking during pregnancy. He reported, "Quite frankly, if the FDA retained jurisdiction over the label of alcoholic beverages, it would waste no time in commencing proceedings to require label warnings."

Over ten years later, alcoholic beverages still carry no health and safety warning labels, although there are a few exceptions. Wine coolers made with saccharin must carry the FDA-required saccharin warning. Champagne bottles have corks bearing a warning about how to prevent eye injuries when opening the bottle. But there are no warnings concerning the alcohol.

After examining the FDA's data on fetal alcohol syndrome, BATF concluded that women of child-bearing age and others should be educated about the risks of mental retardation and birth defects associated with drinking and that the agency did have the authority to require warning labels. However, after publishing its January 1978 advanced notice of proposed rulemaking requiring a warning label about alcohol use during pregnancy, the agency decided to postpone a decision. Instead, further study was to be conducted and the alcoholic beverage industry promised to undertake educational campaigns.

Congressional attention to alcohol warning labels began in 1967, when Senator Strom Thurmond introduced the first health and safety warning label bill. Joining him in sponsoring S. 2500 were six other Senators, including Senator Ernest Hollings.

In 1978, Congressional hearings on alcohol labeling and fetal alcohol syndrome were held by the Senate Subcommittee on Alcoholism and Drug Abuse. One result of those hearings was the introduction of the first bill to propose a transfer of authority over alcoholic beverage labeling to FDA.

In spring 1979, the Senate passed an amendment sponsored by Senator Thurmond requiring the label "CAUTION: Consumption of alcoholic beverages may be hazardous to your health," on all hard liquor products. The Senate Subcommittee on Alcoholism and Drug Abuse responded to the Senate passed amendment by issuing a public call for comment by alcoholism field groups on labeling and by holding full scale hearings on the issue.

These efforts produced the first Congressional recommendations for warning labels on all alcoholic beverages. The Subcommittee reported, "Health warning labels should be required for alcoholic beverages to inform consumers of their risks to health, particularly with respect to birth defects from alcohol consumption during pregnancy. These warnings should apply to distilled spirits, wine, and beer, and to advertising as well as labeling."

Meanwhile, in a House-Senate conference, the Thurmond warning label amendment was dropped. Instead, a report was mandated, to be conducted by the Departments of the Treasury and Health, Education, and Welfare. The agencies were asked to produce a report on actions that should be taken to inform the public of health hazards, including birth defects, associated with alcoholic beverages.

The report was delayed and not released until November, 1980, shortly after the election of President Reagan. It rejected health warning labels, but was accompanied by an unusual White House disclaimer expressing disagreement with its conclusion. Instead of labels, a series of federal and private sector strategies were recommended to educate the public, few of which have been implemented to date.

In 1981, the Surgeon General issued an Advisory which alerted pregnant women and women considering pregnancy to abstain from alcoholic beverages. In 1985, Congressional hearings on fetal alcohol syndrome raised this issue again.

Health and safety warning label bills continued to be introduced in both the House and Senate and in 1986, the Senate Labor and Human Resources Committee unanimously approved an amendment to require rotating health warning labels on all alcoholic beverages. Unfortunately, this bill languished on the

Senate calendar and died with the adjournment of the 99th Congress.

When the 1986 Omnibus Anti-Drug bill was passed, a warning label provision was included -- but this was only for another study, this one to be completed by the Public Health Service on the potential impact of health warning labels on raising public awareness of the risks associated with the use of alcohol. The study, mandated for completion within six months of enactment of the law, was sent to Congress over six months late, in August 1988. It found that health warning labels do have the potential to affect consumer knowledge and behavior, particularly in combination with other educational efforts.

When the Department of Health and Human Services sent its report to Congress, they also sent a copy to BATF, where yet another study was underway. This study, requested by Senator DeConcini and the Senate Appropriations Treasury-Postal Service Subcommittee, was scheduled for release last January. As Mr. Burke, HHS Secretary Bowen's Chief of Staff, testified before this Committee in May, the BATF study is to include a nationwide public opinion poll on warning labels and will assess their effectiveness as an educational tool. The report is due shortly after this year's Presidential elections -- almost eight years to the date of the last BATF study on warning labels.

At hearings on alcohol labeling held this August by the Senate Commerce Committee, William Drake, Assistant Director of BATF, read a statement requesting that Congress hold off on any legislative action until the BATF concludes this study on consumer attitudes on labels. The day of his statement, The Washington Post reported that the Office of Management and Budget had cleared BATF testimony favoring warning labels. The action was reversed after the industry learned of the decision and an "internal fight at the White House," according to the Post.

Federal Regulatory Authority Over Labeling of Alcoholic Beverages

The history of this issue clearly demonstrates how federal assignment of regulatory authority over alcohol has hampered efforts to educate the public about alcohol. Regulation is left primarily to the Treasury Department, an agency whose main intent and responsibility is the collection of federal taxes.

In a 1976 court case, a federal judge in Kentucky ruled that Congress had implicitly exempted alcohol labeling authority from the Food, Drug, and Cosmetic Act, and that BATF therefore had exclusive responsibility for alcohol labeling. Although the FDA prepared a brief to appeal the decision, the Department of Justice never filed it.

Alcoholic beverages are in a class by themselves -- exempt from traditional consumer information programs for all other foods and drugs except tobacco, and from regulation by the agency charged with protecting the public health -- the Department of Health and Human Services. The history of efforts to require warning labels exemplifies what the alcoholic beverage industry has come to know and rely on: that the Treasury Department's Bureau of Alcohol, Tobacco and Firearms does not have as its mission or its expertise, the development of policies that would protect the public health.

Consumer Information About Alcohol Absent

According to the Public Health Service's 1988 Report on the effectiveness of warning labels, consumer information campaigns are especially important. Americans' perceptions of risk are often inaccurate. When it comes to alcohol, the most used and misused drug in our country, the absence of consumer information from labels denies consumers the information necessary to properly assess the risks of drinking. It also implies, by omission, an assurance from the government that all alcoholic beverages are safe for all consumers at all times.

Consumers are also left in the dark as far as alcoholic beverage ingredient and calorie information is concerned. They are systematically denied alcohol content information that would allow them to choose the alcoholic beverage with the lowest, or even the highest, alcohol content -- containers of wine indicate the percentage of alcohol by volume, and containers of distilled spirits indicate proof, which is measured on a different standard. Beer containers do not even mention the word alcohol. All alcoholic beverage containers should carry clear, consistent information using the same unit of measure. We would recommend the percent of alcohol by volume.

BATF has the authority to require the listing of the ingredients in alcoholic beverages. More than 1.5 million Americans suffer serious, sometimes fatal, reactions to some of the dozens of preservatives and other additives in beer, wine, and liquor. Twice, BATF has proposed rules that manufacturers fully list the ingredients on their products' labels. Neither rule went into effect due to opposition by alcohol producers. Meanwhile, the FDA requires ingredient listings for virtually all foods, as well as a host of other products, including dog foods and shampoos.

Today, BATF requires the disclosure of only a few ingredients in alcoholic beverages - sulfites and Yellow Dye No. 5. After years of public pressure, lawsuits, and Congressional attention, alcoholic beverage manufacturers are virtually exempt from ingredient labeling requirements which have been strongly supported by the Food and Drug Administration through the Ford, Carter, and Reagan administrations. For weight-conscious consumers, information about the number of calories in these beverages is also absent.

Concern about under-age drinking, voiced by BATF in its 1980 warning label study, has not been translated into action. For example, now that the drinking age has been raised to 21 in all 50 states, BATF could require a label which states, "This beverage, which contains the drug alcohol, is not for legal sale to anyone under age 21." This type of strategy, which would promote public health, is simply not a priority at BATF, an agency whose primary concerns are the economic aspects of alcoholic beverages.

BATF's failure to adequately regulate with public health as a priority has left consumer, public health, and organizations concerned about alcoholism with only one recourse: to go to Congress and other legislative bodies for relief.

Warning label and other prevention policies are being debated before city and county commissions, state legislatures, and Congress. Policies to warn consumers about the health and safety risks associated with drinking are no exception. For the last five years, a growing number of cities, counties, and states have been enacting legislation requiring the posting of signs wherever alcoholic beverages are sold that warn about the dangers of drinking during pregnancy. One of the first cities is in your own state Senator Glenn, Columbus, Ohio. Four states, Georgia, Maine, South Dakota, and Utah, now have warning poster requirements. In addition, major metropolitan areas, including Washington, DC, New York City, Los Angeles, and a host of counties and smaller municipalities now require warning posters.

These campaigns have not been supported by alcoholic beverage producers. Even the simple educational device of a warning poster, which affects retailers, restaurants, and bars, has been opposed. For example, under California's Proposition 65, the state's Scientific Advisory Panel declared alcohol to be a reproductive toxin. In response, the state's Health and Welfare Board announced that, effective October 1 of this year, warning posters informing consumers about the dangers of drinking during pregnancy would be required in all of the over 68,000 licensed alcohol outlets in that state. While consumer and public health organizations have petitioned for warning labels as a more effective way to inform consumers, the alcoholic beverage industry opposes even the poster requirement and is fighting its implementation.

Federal Legislation Needed This Year

Educational campaigns about the risks of drinking during pregnancy, drinking and driving, and drinking while taking other drugs, have been undertaken by many non-profit organizations and local, state, and federal governmental agencies.

For the over 100 national and state organizations endorsing federal health and safety warning label legislation this year, these educational campaigns aren't enough. They advocate the federal government's adoption of one of the simplest public health educational tools available to alert consumers about the risks of alcohol -- health and safety warnings on each container of beer, wine, hard liquor, or cooler sold.

They were spurred on in that resolve by recent press reports about the anti-acne drug Accutane. Under federal regulations, warnings are required for any drug with the reproductive toxicity of alcohol. When it was discovered that there were 62 cases of birth defects caused by pregnant women taking Accutane, the national media, scientists, and the FDA all directed their attention to the drug. Experts worried about how to rewrite the patient insert and packaging so that consumers would be forced to read the warning information.

While the Accutane debate was quickly resolved, alcoholic beverages, the leading preventable cause of mental retardation and birth defects, carry no health and safety warnings. And, to date, no major manufacturer of alcoholic beverages urges women to follow the Surgeon General's 1981 Advisory and abstain from drinking during pregnancy. Alcoholic beverages enjoy a "Most Favored Product" status that we can no longer afford.

Unfortunately, as the BATF and HEW determined in 1980, "While the public generally knows that alcohol abuse can cause serious health problems for the abuser and individuals who come in contact with him or her, the Departments do not believe that the public is sufficiently aware of all of the specific short and long term effects of alcohol on the health and well-being of different individuals."

The vast majority of American consumers simply don't know, and don't have access to, the information they need to decide when and when not to drink. A May 1986 Advanced Data Bulletin #119 from the National Center of Health Statistics found that Americans are less knowledgeable about the effects of alcohol on health than they are about the effects of smoking, with the exception of cirrhosis of the liver. Only one-third of those surveyed knew that heavy alcohol use was associated with cancers of the throat and mouth. A 1985 Health Promotion and Disease Prevention Survey found only 57% of Americans of all ages had heard of Fetal Alcohol Syndrome.

Consumers Want Information About Alcohol

The desire for information about alcohol is reflected in the strong public support for health and safety warnings by the

American public. In the most recent public opinion poll, conducted by George Gallup in 1986, 80% of those surveyed supported warning labels.

Groups endorsing warning label bills now before Congress include organizations concerned about alcoholism and alcoholism treatment, such as the National Council on Alcoholism, the National Association of State Alcohol and Drug Abuse Administrators, the National Association of Alcohol and Drug Abuse Counselors, and the National Association of Children of Alcoholics. Mothers Against Drunk Driving, Remove Intoxicated Drivers, and other organizations represent victims of drinking and driving fatalities and accidents.

The American Cancer Society, the American Heart Association, the American Liver Foundation, the American Medical Association and the American Public Health Association have special concerns about the illnesses that can be caused by alcohol. Consumers Union, the Consumer Federation of America, and Public Citizen's Congress Watch want consumers to know that alcohol and drugs don't mix.

Parents' groups like the National PTA, the National Federation of Parents for Drug-Free Youth, the Just Say No Foundation and the National Association for Children of Alcoholics want kids to know that alcohol is a drug and may be addictive. The American Academy of Pediatrics, the March of Dimes, and the Association for Retarded Citizens of the US want all women who are pregnant or considering pregnancy to know that the Surgeon General advises them not to drink.

Religious organizations including the United Methodist Church, Presbyterian Church USA, the American Council on Alcohol Problems and the Church of Jesus Christ of Latter-Day Saints also support the warning labels as an important service a government must render to its citizens -- providing accurate information on which to make their consumer decisions.

The many organizations supporting federal warning label legislation view the labeling of alcoholic beverages with specific health messages as an important component of a comprehensive strategy to address alcohol-related problems and alcoholism in our country. While I am testifying on behalf of the Center for Science in the Public Interest today, I have attached a list of the organizations endorsing federal health and safety warning label legislation.

What Information Do Consumers Need About Alcohol?

In July of this year, Dr. Koop issued "The Surgeon General's Report on Nutrition and Health." The report, which has been criticized for its lack of specificity regarding recommendations for Americans to follow in their diet to reduce intake of fats and cholesterol, sodium, and weight control, was specific in one area -- alcohol.

"RECOMMENDATIONS: To reduce the risk for chronic disease, take alcohol only in moderation (no more than two drinks a day), if at all. Avoid drinking any alcohol before or while driving, operating machinery, taking medication, or engaging in any activity requiring judgement. Avoid drinking alcohol while pregnant."

The Surgeon General then went on to explain that alcohol is a drug that can produce addiction and has been associated with disrupted family functioning, suicides, and homicides, as well as liver disease, stroke, high blood pressure, and some types of cancer.

Under bills introduced in this session of Congress, all alcoholic beverages -- beer, wine, hard liquor, and coolers -- would be labeled to cover the proven health risks the Surgeon General identified in his Report.

On August 10, the Senate Commerce Committee held hearings on one of those bills, S. 2047, which, Senator Glenn, we are grateful to you for co-sponsoring. I would like to submit for the record the testimony given before that Committee by the National Council on Alcoholism on behalf of the organizations endorsing warning labels on alcohol.

At those hearings, Dr. Enoch Gordis, Director of the National Institute on Alcohol Abuse and Alcoholism, provided testimony on the scientific evidence supporting each of the five specific warnings. Also appearing at the hearings was a panel of prominent physicians and researchers in the field of alcoholism, each highlighting the need for warning labels. The witnesses included Dr. Kenneth Jones, the pediatrician who identified Fetal Alcohol Syndrome in 1971; Dr. John Morris, Director of the Division of

Trauma, Vanderbilt Medical Center, Dr. Sheila Blume, psychiatrist at South Oaks Hospital and nationally recognized alcoholism authority, and Dr. LeClair Bissell, physician and alcoholism researcher.

Absent from the hearings were any representatives of the alcoholic beverage industry, who had been invited to testify but chose not to attend.

The bill before the Committee would have required five labels, which would rotate just like the ones on cigarettes and smokeless tobacco do.

The proposed warnings would cover five areas:

Drinking During Pregnancy

According to the National Institute on Alcohol Abuse and Alcoholism, alcohol is the leading cause of mental retardation caused by known teratogenic agents. Fetal Alcohol Syndrome (FAS) is the leading preventable cause of birth defects. Over 5,000 children are born each year with FAS, and the cost to society to raise one FAS child is an average of $405,000 in direct special services from birth to age 65.

In 1980, the Research Triangle Institute estimated the costs associated with FAS: Caring for babies cost $14.9 million; 68,000 children under the age of 18 cost $670 million; and 160,000 adults cost $760 million. Indirect productivity losses were set at $510.5 million. These figures do not include the costs associated with infants born with less severe alcohol-related birth defects, known as Fetal Alcohol Effects.

Drinking and Driving

Over 50 percent of all highway fatalities are alcohol-related. About 2 out of every 5 people in the U.S. will be involved in an alcohol-related crash in their lifetimes and alcohol-related highway crashes killed nearly 9,000 15-24 year olds in 1986, making them the leading killer of youths in this age group. Despite the massive voluntary, industry, and government-financed public education campaigns about the dangers of drinking and driving, the number of incidents continue to increase.

Drinking in Combination with Other Drugs

The use of alcohol with prescription, over-the-counter, or illicit drugs is particularly dangerous because when combined, the interaction can create an effect far more dangerous than the two drugs separately. Because alcohol-drug interactions have been reported to be the most frequent cause of drug-related medical crises in the U.S., there are numerous consumer information and education programs about these dangers. Some federal programs already require warning labels, but not on the drug, alcohol.

Drinking and Increased Risk of Hypertension, Liver Disease, and Cancer

Alcoholic cirrhosis is the most dangerous consequence to the liver from drinking, causing at least 11,000 deaths in the U.S. annually. And, although most evidence indicates that development of liver cirrhosis requires the chronic consumption of large amounts of alcohol, newer studies suggest an increased risk in men who drink as little as three drinks a day.

According to the National Institute on Alcohol Abuse and Alcoholism, "Alcohol consumption, either alone or in combination with smoking, increases the risk of cancers of the gastrointestinal tract, particularly of the mouth, pharynx, larynx, and esophagus."

In April, California's Scientific Advisory Panel, advising Governor Deukmejian on the implementation of Proposition 65, unanimously agreed to place alcoholic beverages on its list of chemicals known by the state to cause cancer. According to Committee chair Wendell Kilgore, "A strong connection between alcoholic beverages and cancer has been shown in human studies involving high levels of alcoholic beverage consumption." Last year, the World Health Organization's International Agency for Research in Cancer announced that it had reached the same conclusion, but it has not released its findings yet.

Alcohol is a Drug and May Be Addictive

Over 10 million Americans are addicted to the legal drug alcohol. These individuals, and the 28.6 million children of alcoholics, 6.6 million of whom are under the age of 18, know that alcohol is a drug and may be addictive.

In June, the White House Conference for a Drug-Free America issued its recommendations, among them an endorsement of warning labels on alcoholic beverages. That recommendation and the endorsement of warning labels by numerous parents' organizations, stems from a glaring failure in our drug education programs. A 1987 Weekly Reader Survey of 500,000 elementary school children found that only 50% of fourth graders identified beer, wine and liquor as a drug and the percentage actually decreased to 44% for sixth graders.

The advertising and marketing of all alcoholic beverages has changed dramatically over the past few years, purposefully blurring the distinction between alcoholic and non-alcoholic beverages. It's now possible to buy beer off the shelves of supermarkets and wine coolers at your local K-Mart. The very least we can do is inform consumers, on the label, that alcohol is not soda pop.

While the bill before the Senate Commerce Committee called only for warnings on alcoholic beverages, we believe that the warnings should also be required on all alcoholic beverage advertising, as was first recommended by the Senate Subcommittee on Alcoholism and Drug Abuse in 1979.

Each year, the alcoholic beverage industry spends over $2 billion on advertising and promotions. Frequently, ads glamorize drinking, providing consumers with no information about the health and safety risks associated with the products. Until we decide on ways to provide equal time for professionally produced health and safety messages, all promotional materials should carry the same information as proposed in the labels. For broadcast ads, the message could be aired in the closing one-third of an ad. Similarly, billboards, magazine, and other print ads should all be required to carry the warnings, just as cigarette ads do.

Alcoholic Beverage Industry Opposes Warning Labels

Lined up in opposition to rotating health warning labels is the alcoholic beverage industry. This powerful lobby doesn't want consumers to associate drinking with mental retardation and death on the highways, although they do sponsor occasional ads to remind us to drink "moderately." Unfortunately, those ads are designed more to undercut prevention-oriented legislation, like health and safety warning labels or messages in all advertisements, than to educate consumers about health risks.

Until now, the industry has successfully held off action on warning labels, but the health consequences continue to pile up in treatment centers, half-way houses, city streets, and cemeteries.

Alcohol producers have argued that labels stigmatize light and moderate drinking as being unsafe. They believe this is misleading since they want consumers and policy makers to believe that it is only excessive drinking that is harmful. In some instances, light and moderate drinking is unsafe. Pregnant women have been advised by the Surgeon General not to drink at all. Anti-drinking and driving campaigns, sponsored by citizen organizations, insurance companies and the alcoholic beverage industry promote the use of designated drivers. That's because if you're going to be driving, or sailing a boat, or using dangerous machinery, you should avoid drinking. These campaigns also carry a subtle, disturbing second message, that if you're not the designated driver, you can drink heavily.

Opponents have also argued that labels will injure the credibility of the government. Unfortunately, as the Accutane warnings indicate, the federal government has ignored alcohol to such a degree that even the most basic, proven techniques to inform consumers about alcohol, have not been implemented. The "credibility gap" rests with the $75 billion a year alcoholic beverage industry that can't afford moderate drinking. Its best customers are heavy drinkers, who account for half of all sales.

Senate Commerce Committee Approves Warning Label Compromise

Last week, the Senate Commerce Committee unanimously approved a compromise warning label bill. After rebuffing an offer by Senator Orrin Hatch to negotiate a compromise bill last spring, after refusing to testify before the Senate Commerce Committee, and after pressure generated by warning supporters (including former First Lady Betty Ford, HHS Secretary Dr. Otis Bowen, and former Senator Harold Hughes) mounted, the alcoholic beverage industry, acting through Senator Wendell Ford, agreed to a compromise warning bill.

The bill would require one label on all alcoholic beverage containers. The label would read:

"GOVERNMENT WARNING: 1. According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects. 2. Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery, and may cause other health problems."

It's been over ten years since FDA Commissioner Kennedy first recommended warning labels about the dangers of drinking during pregnancy. We believe S. 2047, if enacted, would represent a tremendous victory for American consumers. Warning labels on alcoholic beverages are long overdue.

Of course, the compromise bill does not do everything we had hoped to accomplish. We are concerned with the fact that the bill would preempt states from requiring their own warnings, especially because some of the specific health risks identified by the Surgeon General and contained in the original bill are no longer mentioned. We are also concerned that the proposed label speaks of other health risks without identifying what they are.

Despite these reservations, we believe that S. 2047 will make an important contribution to informing consumers about some of the specific, proven risks associated with drinking and look forward to its enactment this year.

Health warnings on alcohol alone won't reduce or eliminate alcohol-related problems. They are only one part of a far more comprehensive effort we must commit ourselves to prevent needless alcohol-related tragedies. There is much more that must be done.

Prevention Research and Education Programs

Just a few of the prevention research topics that aren't being funded by the National Institute on Alcohol Abuse and Alcoholism include research on the impact of alcohol advertising on children and alcoholics; the effectiveness of pro-health messages; and the overall impact of alcoholic beverage marketing on alcohol-related problems.

The National Institute on Alcohol Abuse and Alcoholism's budget's priorities reflect the low ranking of prevention research. The prevention portion of NIAAA's budget has declined steadily over the past few years until it received only a little more than 6 percent of the total dollars spent on research in FY 1987. Despite the infusion of federal dollars to alcohol and drug programs under the 1986 Anti-Drug Act, only $3.7 million was spent on prevention-oriented research in FY 1987. The Office for Substance Abuse Prevention targets prevention programs to high-risk youth, with virtually no federal prevention efforts underway for other Americans.

With an alcoholic beverage industry intent on expanding its market, where are the prevention programs to inform consumers that the Sun Country Coolers advertised on TV and available at their local grocery store contain alcohol, indeed have an alcohol content greater than most beers? And who is conducting research on the marketing of Yago, another wine cooler, in a package that looks like my daughter's favorite fruit juice container, on alcohol-related problems and alcoholism?

Although some state and local alcohol and drug programs have carried out innovative prevention programs, such as New York States's poster and broadcast ad campaign informing consumers that wine coolers are a drug and contain alcohol, the primary responsibility for researching and monitoring the impact of the alcoholic beverage industry's advertising and marketing practices on alcohol-related problems and alcoholism should rest with the federal government. The federal government should be developing and carrying out innovative, creative research and education programs to prevent alcoholism and alcohol-related problems.

We need to understand what the costs of alcoholic beverage products are to our society and take steps to reduce them. One way we could do that is to require producers to file an "alcoholism impact statement" before new product lines are introduced. There are many other activities that the federal government could undertake to assume a much needed active role in fighting alcohol-related problems.

Federal Regulatory Authority over Alcohol

The Department of Health and Human Services should become the lead regulatory agency for alcoholic beverages. When HHS Secretary Bowen announced his First National Imitative on Alcohol Abuse and Alcoholism last fall, we frankly were disappointed. Many of his recommendations involved simply discussing public health initiatives with other federal agencies, in the hope that they would be convinced to take action.

Alcohol problems are far too grave to be left to such a "regulatory" system. The present federal effort overseeing alcohol policies is severely flawed. Unless priorities are changed, effective prevention programs will suffer from further neglect. The present system of federal regulation of alcoholic beverages has denied consumers more than health and safety warning labels.

HHS Secretary Bowen included in his national alcohol initiative the need to address advertising and promotional campaigns on college campuses, over which HHS has no authority. This past spring, the Miller Brewing Co. distributed brochures on college campuses across the country, including George Washington University, which has a substantial undergraduate, below-legal-drinking-age student population. The brochure discouraged kids from getting a job over spring break, "Get a job. Nah!" and invited them to come to the Miller Spring Break Oasis in Daytona Beach, or the Miller Welcome Centers in Ft. Lauderdale, Pensacola, Ft. Walton, or Myrtle Beach. Once there, they were invited to preview clips from some of last summer's hottest movies, all of which just happened to feature the use of Miller Beer as props. One brochure includes a brief "moderation" message, encouraging kids not to drink and drive, and to eat well, buckle up, and beware of sunburns.

BATF has yet to address Spring Break promotions, either on college campuses, or in Florida and other Spring Break areas. Yet, it has the authority to do so. This failure to act is just one more reason to move responsibility over alcohol to an agency whose mission is protection of public health, the Department of Health and Human Services.

Senator Glenn, as you know, the alcoholic beverage industry is very powerful. It is using every resource at its command to convince consumers and elected officials that alcoholism, drinking and driving fatalities, mental retardation, and the dismaying list of other alcohol-related tragedies have nothing to do with their products or how they are promoted. We hope that Congress will have the ability to stand up to that industry and pass legislation that most Members know is needed.

I appreciate the opportunity to come before you today and thank you for your interest and welcome the opportunity to assist you in whatever way we can.

Alcohol Advertising: A Call for Congressional Action

Statement of

Jean Kilbourne, Ed.D.

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to the

Committee on Governmental Affairs

United States Senate

SEP 2 7 1988

My name is Jean Kilbourne. I have been doing research on alcohol advertising for over ten years. I lecture internationally on the topic and have created a film entitled "Calling the Shots: The Advertising of Alcohol." I am the Vice Chair of the Council on Alcohol Policy of the National Association for Public Health Policy. I am also on the Board of Directors of the National Council on Alcoholism and am the Co-Chair of the Prevention and Education Committee. In addition, I am on the National Advisory Committees of the alcohol education projects of both the Junior League and the Women's Action Alliance.

I welcome the opportunity to address your Committee on the influence of alcohol advertising on our society and the role of the federal government in counteracting this influence.

Overview:

Alcohol is the nation's number one hard drug. At least ten percent of all the deaths in the United States are related to alcohol misuse, including nearly half of all deaths in automobile accidents, homicides, and suicides. At least eighteen million Americans are alcoholics or problem drinkers; the personal cost to them and their families is immeasurable.[1] The economic cost to the nation exceeds one hundred and twenty billion dollars a year.

As these grim statistics escalate, alcohol remains one of the most heavily advertised products in the nation. Alcohol industry revenue is over sixty-five billion dollars a year. The alcohol industry spends over 1.3 billion dollars a year on advertising.[2] In 1986 Anheuser-Busch's annual budget for just one brand, Budweiser, was $110 million[3], far more than the entire federal budget of $65 million for the National Institute on Alcohol Abuse and Alcoholism.[4] Young people and heavy drinkers are primary targets of the advertisers.

Advertising does not cause alcoholism. Alcoholism is a complex illness and its etiology is uncertain. However, alcohol advertising does create a climate in which dangerous attitudes toward alcohol are presented as normal, appropriate, and innocuous. One of the chief symptoms of the illness of alcoholism is denial that there is a problem. It is often not only the alcoholic who denies the illness but also his or her family, employer, doctor, etc. In general, as a society we tend to deny the illness and to support the alibi system of the alcoholic. Alcohol advertising can encourage this denial. It can create a world in which myths about alcohol are presented as true and in which signs of trouble are erased or transformed into positive attributes.

Most advertising is essentially myth-making. The point of almost all national advertising is not to give us information about a product but rather to establish an image for the product. Advertising does this by linking the product with a quality or attribute. The jeans will make you sexy, the detergent will save your marriage, the car will give you confidence. According to an article in Advertising Age on beer marketing, "Advertising is as important to selling beer as the bottle opener is to drinking it ... Beer advertising is mainly an exercise in building images."[5] Another article a few months later on liquor marketing stated that "product image is probably the most important element in selling liquor. The trick for marketers is to project the right message in their advertisements to motivate those often motionless consumers to march down to the liquor store or bar and exchange their money for a sip of image."[6]

The links are generally false and arbitrary but we are so surrounded by them that we come to accept them, to believe that they are logical and natural. This myth-making is always deceptive and often harmful. In the case of alcohol advertising, however, it can be truly dangerous. It further convinces the alcoholic (and often those around him or her) that the drug is benevolent and essential. Most important, alcohol advertising spuriously links alcohol with precisely those attributes and qualities -- happiness, wealth, prestige, sophistication, success, maturity, athletic ability, virility, creativity, sexual satisfaction, and others -- that the misuse of alcohol usually diminishes and destroys.

For example, alcohol is often linked with romance and sexual fulfillment (an ad for a liqueur proclaims, "The romance never goes out of some marriages"), yet it is common knowledge that alcohol misuse often leads to sexual dysfunction. Less well known is the fact that people with drinking problems are seven times more likely to be separated or divorced than the general population.[7]

Effects on Consumption:

Because of the number of variables involved and the extreme difficulty of finding comparison groups who have not been exposed to advertising, it may be impossible to prove conclusively, at least to the skeptic, that advertising increases alcohol consumption. Many feel that the burden should be on the alcohol industry to prove that it does not. An editorial in Advertising Age concluded: "A strange world it is, in which people spending millions on advertising must do their best to prove that advertising doesn't do very much!" [8] The results of what little high-quality, independent research has been done on this topic are equivocal. There is, however, general agreement that advertising affects consumption beyond particular brands and can promote an entire category or market. According to Advertising Age, "Thus advertising for Smirnoff vodka helps Smirnoff sales, but it also gives a boost to vodka in general."[9] The milk, coffee, and orange juice trade associations of America all run generic ads for these products, obviously believing that these ads will increase consumption.

Research does indicate that alcohol advertising contributes to increases in youthful consumption and serves as a significant source of negative socialization for young people.[10] Perhaps the socializing function of advertising is more important than its immediate effects on consumption. Social learning theory suggests that repeated exposure to modeled behavior can result in behavioral change.[11] Atkin and Block's 1981 study found that adolescents and young adults more heavily exposed to alcohol ads on television and in magazines are more likely to perceive drinking as attractive, acceptable and rewarding than are those who have been less exposed.[12] Their 1984 study of teenage drinking found that young people who say they have seen more television and magazine ads for alcohol generally drink more or expect they will begin drinking and that "[a]dvertising is more strongly related to both beer and liquor drinking than is parental influence, age, sex, church attendance, social status, or viewing alcohol in entertainment programming." 13

Those who argue that peer pressure is the major influence on young people strangely overlook how the "peers" themselves are socialized. Advertising is a powerful educational force in American culture, one which promotes attitudes and values as well as products.[14]

> By presenting drinkers in carefree social and sexual situations, alcohol commercials connote the harmlessness and acceptability of alcoholic beverages and suggest that alcohol consumption is a particularly positive activity. This visual barrage of attractive and seductive messages infiltrates the audience's consciousness and creates an unconscious presumption in favor of drinking.[15]

In 1987 the AAA Foundation for Traffic Safety released a study by university media communication specialists that suggests that television beer commercials play a significant role in the overinvolvement of males in alcohol-impaired driving. The report, Myths, Men and Beer: An Analysis of Beer Commercials on Broadcast Television, 1987 calls for a review of public policies related to beer commercials. The report states that beer is represented in these commercials as an essential element in masculinity, "so that one cannot be attained without the other -- a powerful, distorted and dangerous message to broadcast to young people."[16] [Copies of this report for all Committee members are included with this testimony.]

A recent article on alcohol advertising and adolescent drinking in Alcohol Health & Research World concluded:

> ... Limited studies already suggest that advertisements can influence young people's attitudes toward alcohol. Moreover, findings from research on other substances (e.g. cigarettes) provide further evidence for a link between advertising, attitudes, and behavior among youth. Thus, efforts both to reduce the amount of alcohol advertising to which young people are exposed and to correct the misleading perceptions furthered by these advertisements appear to be worthwhile prevention strategies.[17]

Glorifying the Symptoms of Alcoholism:

"It separates the exceptional from the merely ordinary." This advertising slogan for champagne headlines a photograph of an enraptured couple in full color drinking champagne surrounded by people in black and white masks with somber expressions. This ad illustrates the major premise of the mythology. Alcohol is magic. It is a magic carpet that can take you away. It is a magic potion that can transform you. It can make you successful, sophisticated, sexy. Furthermore, it is necessary if you are to be these things. Without it, you and your life are dull, mediocre, ordinary. In fact, this ad implies that without it, you are dead. The people who are not drinking the champagne are lifeless replicas of the happy couple who are imbibing; they are zombies. The alcohol has rescued the couple, resurrected them, restored them to life. At the heart of the alcoholic's dilemma and denial is this belief, this certainty, that alcohol is essential for life, that without it he or she will literally die -- or at best be condemned to a gray and two-dimensional wasteland, a half-life. This ad, and many others like it, present that nightmare as true, thus affirming and even glorifying one of the symptoms of the illness.

Such glorification of the symptoms is common in alcohol advertising. "Your own special island," proclaims an ad for rum. Another ad offers a beer as "Your mountain hide-a-way." Almost all alcoholics experience intense feelings of isolation, alienation, and loneliness. Most make the tragic mistake of believing that the alcohol alleviates these feelings rather than exacerbating them. The ads take that symptom and turn it around, just as the alcoholic does. You are not isolated and alone; you're on your own special island.

This ad also seems to be encouraging solitary drinking, a sign of trouble with alcohol. It features a tray containing a full bottle of rum and one glass (also filled). There is no room for another glass on the tray.

Although it is unusual for solitary drinking to be shown (most alcohol ads feature people in groups or happy couples), it is not unusual for unhealthy attitudes towards alcohol to be presented as normal and acceptable. The most obvious example is obsession with alcohol. Alcohol is at the center of the ads just as it is at the center of the alcoholic's life. The ads imply that alcohol is an appropriate adjunct to almost every activity, from making love to white-water canoeing. They imply that daily drinking is simply fine and perhaps even necessary. An ad for rum says, "You know how to make every day special. You're a white rum drinker," and one for Scotch tells us, "At the end of the day, even a bridge seems to be heading home for Red." In fact, less than ten percent of the adult population drinks daily (and many of those drinkers are in trouble).

There is also an emphasis in the ads on quantity. Another Scotch ad features sixteen bottles of Scotch and the copy, "Bob really knows how to throw a party. He never runs out of Johnnie Walker Red." Light beer has been developed and heavily promoted not for the dieter but for the heavy drinker. It is less filling and therefore one can drink more.

Thus the ads tell the alcoholic and those around him or her that it is all right, indeed splendid, to be obsessed by alcohol, to consume large quantities of it on a daily basis and to have it be a part of all one's activities. At the same time, all signs of trouble and any hint of addiction are erased. Every instance of use seems spontaneous, unique. The daily drinking takes place on yachts at sunset, not at kitchen tables in the morning. Bottles are magically unopened even when drinks have been poured (as in the "Your own special island" ad). There is no drunkenness, only high spirits. There are never any negative consequences.

Alcohol is related to parties, good times, celebrations, and fun, but it is also related to murder, suicide, unemployment, and child abuse, and these connections are never made in the ads. Of course, one would not expect them to be. The advertisers are selling their product and it is their job to erase any negative aspects as well as to enhance the positive ones. However, when the product is a drug that is addictive to one in ten users, there are consequences that go far beyond product sales.

Censorship in the Media:

We are surrounded by the message that alcohol is fun, sexy, desirable and harmless. We get this message hundreds of times a day. We get it from the ads and, far more insidiously, we get it from the media, which depend upon alcohol advertising for a large share of their profits. Alcohol use tends to be glorified throughout the media and problems associated with alcohol misuse are routinely dismissed. A 1981 cover story in Time did mention that violent crime is linked with drug abuse. The only drug mentioned by name in the article was marijuana. Alcohol was not mentioned although it is certainly the drug most linked with violent crime (more than all other drugs combined). There were five full-page, full-color ads for alcohol in that issue of Time. On November 30, 1987, Time ran a cover story on alcoholism; there were no alcohol ads in that issue of Time. Within a few months of this issue, Newsweek, U.S. News and World Report, and People all ran cover stories on alcoholism; there was only one ad for alcohol in all these issues (and it was a half-page ad). How often could these magazines afford to do such stories?

In 1983 and 1984, Ms. Magazine devoted the entire May issue to women and health, dealing with everything from fat cells to foot care. However, there was not a single reference to alcoholism or alcohol misuse, not even in articles dealing with pregnancy (alcohol misuse is a major cause of preventable birth defects). Alcoholism is arguably the nation's number one health problem for women as well as for men, but there was no mention of it in either of these special issues of Ms -- which carried thirteen full-page, full-color ads for alcohol in 1983 and ten in 1984. In February 1987 Ms devoted the entire issue to addictions and did include alcohol; there were no ads for alcohol in that issue.

Media coverage of the "war on drugs" routinely eliminates the two major killers, alcohol and cigarettes. One would assume from the coverage that cocaine was the nation's most dangerous drug. However, in 1986 cocaine, heroin, and other illegal drugs were linked with about 3500 deaths[18], alcohol with at least 100,000, and cigarettes with over 350,000. Alcohol and cigarettes are two of the most heavily advertised products in the nation. At least one third of all outdoor advertising revenue is from alcohol and cigarette ads.[19] Is it possible to get accurate information about alcohol (and cigarettes) in such a climate?

For this reason alone we need some controls on alcohol advertising. One doesn't even have to enter into the argument about whether such advertising increases consumption. At the very least, it drastically inhibits honest public discussion of the problem in the media and creates a climate in which alcohol is seen as entirely benign.

In addition to this general cooptation of the media by the alcohol industry, ads for products other than alcohol often perpetuate stereotypes about alcohol and alcoholism. For example, a recent ad for a printing company that ran in Time and Newsweek features a dapper executive who ends up on Skid Row after using the wrong printing company. Fewer than three percent of alcoholics are derelicts. Far more alcoholics resemble the man in his "before" state rather than in the "after" state. Yet the stereotype of the alcoholic as derelict persists, making it difficult for the overwhelming majority of alcoholics to be identified as such.

Television:

Television also contributes to the glorification of alcohol use and the suppression of any negative consequences. Almost 50% of all alcohol advertising is on television. Each week television reaches 90% of all teenagers and 92% of all children in the country.[20] In addition, the programs often feature heavy drinking. One researcher has estimated that a young person will see alcohol consumed an average of 75,000 times on television before he or she is of legal drinking age.[21]

However, there has been significant change on television in recent years. Television movies have attempted to deal with alcohol problems in a realistic way, as have some shows such as "Hill Street Blues" and "Cagney and Lacey" (and the producers and writers of such programs should be commended). These shows are not particularly popular with young people, however, who are more likely to be watching music video or sporting events, brought to them by wine cooler and beer commercials. There is a great need for more special programs on alcohol directed at youth.

One recent study on alcohol on television found that, although there is still a lot of drinking portrayed, there is less heavy drinking and intoxication. However, the study concluded:

> Alcohol is ubiquitous in television life. The strong suggestion conveyed to viewers is that alcohol is taken for granted, routine and even necessary, that most people drink and that drinking is a part of everyday life. The drinkers are frequently glamorous; for many viewers they are setting an example regarding lifestyle. These images are at variance with the problematic nature of alcohol in society. It would be difficult to make the case that alcohol is being presented in a balanced way on prime-time television. The overall impact may contribute to the normalization of drinking in American life. ... Serious concern about television's contribution to alcohol education is clearly warranted.[22]

A new and alarming aspect of television is the extent to which the programs and commercials are becoming indistiguishable. Television actors, often in character, pitch alcohol in commercials. Bruce Willis of "Moonlighting" and Mark Harmon of "St. Elsewhere" use their much-touted sex appeal to sell Seagram's coolers and Coors beer respectively. "Norm," the heavy-drinking beer-lover on "Cheers," is featured in Meister Brau beer commercials that are often broadcast during the program. It may not be long before commercials are completely integrated into programming. This is already happening in films, especially those aimed at the youth market. Throughout the movie "Spring Break," college students guzzle beer from quart bottles, 12-ounce bottles, cans and plastic cups bearing the Miller logo. The film glamorizes heavy drinking by what appear to be adolescents.

Targeting Heavy Drinkers:

The alcohol industry acknowledges that the abuse of alcohol creates some problems for some individuals, but they claim that they simply want people who already drink to switch to another brand (and, of course, to use it in moderation). This is difficult to believe. About a third of all adult Americans choose not to drink at all, a third drink very moderately (a drink or two a week), and about a third drink regularly. Ten percent of the drinking-age population consumes over sixty percent of all alcohol. This figure corresponds very closely to the percentage of alcoholics in the society. If alcoholics were to recover, i.e. to stop drinking, the alcohol industry gross revenue could be cut in half. Could they want this? On the contrary, they deliberately target the heavy drinker and they devise ads designed to appeal to him or her. As with any product, the heavy user is the best customer. However, when the product is a drug, the heavy user is often an addict.

Another perspective on the industry's claim to encourage only moderate drinking is provided by Robert Hammond, director of the Alcohol Research Information Service. He estimates that if all 105 million drinkers of legal age consumed the official maximum "moderate" amount of alcohol - 0.99 ounces per day, the equivalent of about two drinks -- the industry would suffer "a whopping forty percent decrease in the sale of beer, wine, and distilled spirits, based on 1981 sales figures."[23]

The heavy drinker is worth a great deal to the alcohol industry and they know where to find him or her. The producers of television programs and magazines and newspapers can give the advertisers a great deal of information about their readers, listeners, and viewers. Target audiences are sold to the alcohol industry on a cost per drinker basis. Many people have the illusion that television programs are brought to them by the sponsor. The truth is just the opposite: we are brought to the sponsor by the program. We are the product and we are sold to the advertisers by the producers of a particular medium. Good Housekeeping advertised itself to the alcohol industry as a good place to reach women drinkers with an ad in Advertising Age that proclaimed, "You'll catch more women with wine than with vinegar. She's a tougher customer than ever. You never needed Good Housekeeping more."

Targeting Young People:

The young person, the new consumer, is worth a great deal to the alcohol industry too. Sport magazine sold its young drinkers to the industry with an ad in Advertising Age stating, "What young money spends on drinks is a real eye-opener." The current Spuds MacKenzie campaign for Budweiser is clearly appealing to college students and even young children. The Spuds MacKenzie figure (an English bull terrier) reportedly has been licensed by Anheuser-Busch to the makers of some 200 consumer products, including stuffed animals, dolls, T-shirts, posters and mugs. In one Christmas ad campaign, Spuds appeared in a Santa Claus suit, promoting 12-packs of Bud Light beer. According to Senator Strom Thurmond, "The stuffed animals, children's toys and T-shirts small enough to fit 12-year-olds indicate the real purpose of the campaign is to entice young people to drink. Is this the kind of responsibility which we can expect from the alcohol beverage industry in the future? If so, I think we in Congress should get to work on some major policy changes."[24]

A popular T-shirt on many college campuses proclaims,"I don't have a drinking problem. I drink. I get drunk. I fall down. No problem." In spite of this cavalier attitude, alcohol misuse is considered by many to be the number one health problem on most college campuses and indeed for our nation's youth in general. [25]

The average age at which people begin drinking today is 12.[26] A recent Weekly Reader survey found that over one-third of the fourth-graders surveyed had experienced peer pressure to drink alcohol. [27] In 1985, an estimated 4.6 million adolescents aged 14 to 17 experienced negative consequences of alcohol use, e.g. arrest, involvement in an accident, and/or impairment of health or job performance.[28] The highest rate of problem drinking occurs among young men aged 18-24.[29]

Alcohol-related motor vehicle crashes are the leading cause of death among those under 25;[30] each year, 8000 teens and young adults are killed and another 40,000 are injured in alcohol-related crashes.[31] Alcohol is implicated in at least half of the other major causes of death for young people, i.e. suicides, homicides, and accidents.[32] Alcohol misuse is also often a factor in many of the other problems afflicting this age group, such as teenage pregnancy, date rape, assault, and vandalism.

Advertising is certainly not solely responsible for these grim statistics. However, as discussed above, it may increase consumption among young people and it certainly plays a part in creating a climate of denial. Image advertising is especially appealing to young people, who are more likely than adults to be insecure about their images. Some of the themes are particularly attractive to young people, such as the linking of alcohol with maturity and sophistication, with sex, and with athletic ability. A recent television commercial for Miller beer featured Danny Sullivan, the race car driver, speeding around the track with the Miller logo emblazoned everywhere. (This certainly seemed to be in violation of the Bureau of Alcohol, Tobacco and Firearms governmental guidelines prohibiting the use of active athletes in alcohol ads.) Such commercials are especially disturbing in the light of research that suggests that alcohol advertising plays a role in excessive and hazardous drinking.[33]

The impact of modeling on young people is particularly important given the widespread use of celebrities such as rock stars, television personalities, and athletes, in alcohol ads. Atkin and Block found in their 1981 study that the impact of celebrity advertising was particularly great on under-age youth: "Furthermore, the celebrity character is rated as significantly more trustworthy and competent. These effects are very strong among younger respondents under the age of 18; the celebrity endorsement has little impact on older persons."[34]

The Vice President of Standards and Practices for ABC said recently:

> Role-model actors like Tom Selleck or Don Johnson can do certain things without much comment and have a lot of impact, like Magnum ordering milk in a bar, or Crockett

> deciding to quit smoking. I'm willing to bet that when Don Johnson stopped smoking cigarettes on Miami Vice, that did more to prevent teenagers from starting smoking than a hundred PSAs. It's a very effective form of prevention.[35]

An article in Advertising Age stated:

> Marketers have learned to live with the vagaries of teen opinions and tastes because "it's much easier to sell them at age 15 than at age 22," says Mr. Hauser. They are attempting to diminish the brand-switching problem by trying to get the pre-teen group hooked on their brands before they enter their teen years, Ms. Forcade says. "Pepsi with Michael Jackson is a blunt appeal to young kids. If they start drinking Pepsi at age 11 or 12, the company hopes they'll stay with the brand!"[36]

Can these people claim simultaneously that the celebrities who are pushing alcohol have no impact on the young, e.g. that linking a famous race car driver with Miller Beer will have no influence on the drinking and driving practices of impressionable young people?

Many alcohol ads play on the theme that drinking is the primary ritual into adulthood in our society (e.g. an ad for chocolate liqueur features two people sipping a chocolate soda through straws and the slogan, "Chocolate for grownups"). Others turn soft drinks into alcoholic drinks, often in a way that scoffs at the idea of the soft drink standing alone (e.g. an ad for cherry liqueur features the bottle poised on a can of Coca Cola and the caption, "What's Coca Cola without the Cherry on top?).

A major theme of beer advertising directed at young people is escape and freedom from adult responsibility. One beer slogan is "Head for the mountains." A college poster for another beer features a beer-drinking young man saying on the telephone, "Yeah mom -- I'm studying all about the pyramids!" while two of his friends build a pyramid of beer cans in the background.

Until recently it was the brewers who most heavily targeted young people. The wine industry claimed the moral high ground and generally ran more conservative ads. That position was forfeited when wine coolers hit the market in 1984. Virtually unknown before then, wine coolers are an almost $2 billion industry today.[37]

Wine coolers are sweet, carbonated, and slickly packaged. They are often positioned as alternatives to non-alcoholic beverages rather than as alternatives to other forms of alcohol. Unlike beer and hard liquor, one does not have to develop a taste for them. According to Advertising Age, "[o]ne might say that this product, due to its sweet, cold and refreshing nature, appeals to the 'Pepsi generation'..."[38] A recent survey conducted by the National Council on Alcoholism and Weekly Reader found that the majority of students in grades four to six failed to perceive daily consumption of one wine cooler as being harmful to children their age whereas they did recognize the harm of one drink daily of beer, wine, or liquor or daily use of marijuana, cocaine, or crack.[39] While 45% of these students called beer, wine, or liquor a drug, only 21% said the same of wine coolers (in grades seven to twelve, 25% called wine coolers a drug).[40]

In 1986 the industry spent $150 million on advertising for wine coolers.[41] Many of the ads seem to be directly aimed at young people. The talking polar bear puppets in a recent Sun Country Cooler commercial must be very appealing to children. California Cooler uses pop music and contemporary beach party scenes. California Cooler promotion includes sailboating sweepstakes, stock and NASCAR racing teams, a Long Beach Grand Prix car, and co-sponsorship of a high-performance racing car. This is in direct violation of the Wine Institute's voluntary Code of Advertising Standards which states that wine advertising should not depict or describe wine in conjunction with feats of daring or activities requiring unusual skill and should in no way suggest that wine be used in conjunction with driving.[42] It would seem that the very existence of a cooler called Harley-Davidson also violates this code.

Young women are courted with commercials pushing wine coolers as low-calorie health drinks (although they often are sugar-laden and more caloric than other forms of alcohol). [43] The coolers are often advertised as thirst-quenchers and as a reward after exercise.

Young people are targeted by the alcohol industry throughout the media. Major national magazines such as National Lampoon, Rolling Stone, and Ms. have a high percentage of young readers and carry numerous alcohol ads. Alcohol advertising is also featured on youth-oriented rock stations, and the alcohol industry regularly sponsors rock concerts. Miller currently sponsors sixteen bands around the country, spending about $100,00 to $150,000 per band. [44] One wine cooler commercial featured Bruce Willis in a 60-second rock video directed by David Mallet, the MTV: Music Television award winner who has directed Mick Jagger, David Bowie and Tina Turner videos. Other promotions include a talent Search using local radio stations to find rock and roll talent.[45]

A major way that the industry reaches young people is through direct promotional efforts on college campuses. The college audience numbers over 12 million and is said to be worth about $30 billion to marketers. [46] The brewers in particular sponsor a wide variety of events, from sporting events to drinking contests to rock concerts to rodeos to spring break in Florida. Budweiser once installed in Fort Lauderdale a 5-story inflatable auditorium in the shape of a Budweiser six-pack.[47] A recent Miller Lite promotion targeting college students featured a ski holiday sweepstake, a Miller Lite Ski Phone (for the latest ski conditions), and fifteen items of ski clothing and accessories emblazoned with the Lite logo. The major brewers also hire campus representatives who help students organize parties focused around a particular brand of beer and often distribute free beer (although this practice has abated somewhat recently due to increased awareness of alcohol-related problems on college campuses).

The primary marketing tool on campus is the college newspaper. Although most of the readers are not of legal drinking age, much of the advertising in campus newspapers is for alcoholic beverages. One recent study found that more than 45 times as much space was devoted to alcohol advertisements as to advertisements for soft drinks and almost 20 times as much space as for books.[46] Some of the advertising promotes very unhealthy attitudes toward alcohol. Several years ago an ad ran in many college newspapers that featured a group of very young men enjoying themselves in what looked like a college dormitory or fraternity house. Above the scene was the familiar Michelob slogan, "Put a little weekend in your week." In smaller print the ad informed us, "Freshmen wait for the weekend to have a Michelob. Seniors know better." The national advertisers have been moving away recently from such blatant irresponsibility, probably due to escalating criticism. However, the newspapers often run ads by local advertisers that emphasize heavy drinking, escape from responsibility, and other examples of alcohol misuse, e.g. an ad for a local bar with the headline, "Don't just wet your whistle, drown it."

The national advertisers seem to be concentrating more these days on posters and sponsorship of campus activities. The posters are generally advertised in inserts that are placed in the college newspapers at the printers (and thus circumvent any kind of scrutiny by the editors). Many of these posters are extremely sexist and demeaning to women, e.g. one for beer features a closeup of a young woman's derriere and the caption, "The best little can in Texas." (This certainly seems to be in violation of the United States Brewers Association's guideline which prohibits risque material, suggestive double entendres, etc.) Many emphasize heavy drinking and an inflated role for alcohol in the drinker's life. A recent series of posters offered to students features one of a refrigerator stocked almost entirely with beer. The caption is "Party Headquarters." Another poster features a young man surfing on a gigantic bottle of beer. Such posters are widely used to decorate students' rooms.

It is certainly in the interest of the alcohol industry to have college students drinking heavily. The college market is particularly important not only because of the money the students will spend today on beer but because they are developing habits and even addictions that may be with them for life. They are also developing "brand loyalty," a concept of great importance to advertisers. As one marketing executive said, "Let's not forget that getting a freshman to choose a certain brand of beer may mean that he will maintain his brand loyalty for the next 20 to 35 years. If he turns out to be a big drinker, the beer company has bought itself an annuity."[49]

More recently, Advertising Age reported, "The beer industry as a whole is worried about losing young drinkers to other beverages, including wine or even fruit juice. ... And it's today's youth market that will become tomorrow's high volume drinkers or at least the major factor in the beer market. That's why most major brewers have sizable college campus marketing efforts and why the brewers make the trip to Florida over spring break with thousands of college revelers."[50]

Note the emphasis on the "big" and "high volume" drinker. As discussed above, although the industry often claims to encourage "moderate" or "responsible" drinking, the truth is that only heavy drinking yields sufficient profits.

Some of the programs designed by the alcohol industry to educate students about "responsible drinking" in fact subtly promote myths and damaging attitudes. For example, Miller has a program in which moderate drinking is defined as up to four drinks a day. Budweiser has a program called "The Buddy System" in which drunkenness is interestingly defined as having "had too much of a good time." Doesn't this imply that being sober is having a bad time, that the drunker one is, the better the time one is having? Another Budweiser "prevention" campaign says, "Know when to say when," as opposed to "Know when to say no." Although they may exist, I have never seen an industry program that offers abstinence as a possible choice.

Most of the programs are designed to encourage young people not to drive drunk. Although this is a laudable goal, it is interesting to note that few of the alcohol industry programs discourage or even question drunkenness per se. The emphasis is almost always and only on not driving while drunk, as if this were the only problem. The tragic result is that many young people do feel it is perfectly all right to get drunk, as long as one does not get behind the wheel of a car. Some of the advertising furthers this misconception by featuring alcohol in risky situations, e.g. a poster featuring a skier standing at the top of a mountain, with five bottles of beer in the snow beside him. Another poster headlined "Packin' 24" portrays a scruffy-looking sheriff with a gun in one hand and a case of beer in the other.

Targeting Women and Minorities:

In addition to young people, the industry often targets other relatively powerless groups in the society, primarily women and minority groups, and offers alcohol to these groups as a route to power. "Some people think you can't beat the system," proclaims a Scotch ad. "Here's to those who show the way." Baseball player Curt Flood holds forth a glass of whiskey as if it, rather than courage, were the way. When members of these target groups use alcohol in an attempt to beat the system, it is never the system that ends up beaten. Ads for alcohol (and cigarettes) often stress freedom, independence, control and power because it is precisely these things that addiction takes away.

In 1987 the Center for Science in the Public Interest published a report entitled "Marketing Booze to Blacks" which stated that blacks are increasingly targeted by the alcohol industry.[51] [Copies of this report for all Committee members are included with this testimony.] Hispanics are also especially targeted and liquor commercials run on Spanish-language television in this country.

Until fairly recently women were simply exploited as sex objects in alcohol advertising and were used as symbols of the alcohol. For example, the long-running campaign for Black Velvet usually features a woman dressed in black velvet saying something suggestive such as "Try Black Velvet on tonight."). This exploitation certainly continues. However, the industry is now making a great effort to court women and is using the same tactics as the tobacco industry. Apparently they are having similar success. More women are drinking today and thus, of course, more women are having problems with alcohol.

Women are often offered alcohol as a symbol of and route to liberation and freedom. "Break tradition," proclaims a series of ads for rum featuring women athletes. "It's my beer too," proclaims another female athlete in an ad. These ads are similar to the infamous Virginia Slims campaign featuring the slogan "You've come a long way, baby," which astonishingly equates liberation with addiction, freedom with enslavement to tobacco.

Many alcoholics are female and there are some special problems for women. Alcoholic women are especially stigmatized and the consequences of alcohol misuse for women are often even more severe than for men. The majority of men leave their alcoholic wives whereas the majority of women stay with their alcoholic husbands. Alcohol and drug dependent women report a high incidence of sexual abuse, including rape and incest. Women are often cross-addicted, usually to legal drugs prescribed for them by physicians who are ignorant about alcoholism. Women continue to be under-represented in most alcoholism treatment programs. In addition, fetal alcohol syndrome is the number one preventable cause of birth defects in the nation.

The problem is especially grave for women of color. Among blacks who drink, twice as many black women as black men report health problems dueto drinking. Native American women between the ages of 15 to 34 have rates of cirrhosis of the liver 36 times the white female rate.

Solutions:

The alcohol industry spends over a billion dollars a year advertising its product, a product that is undeniably used moderately and with pleasure by many people but that is also undeniably addictive for and misused by many, with dreadful consequences for the entire society. Certainly it is not only the alcoholic who suffers. According to a recent Gallup survey, one out of three Americans today says that alcohol has been the cause of trouble in his or her family. Countless others are the victims of alcohol-related accidents and crimes. Everyone is affected by the economic and psychological costs.

A major comprehensive effort is needed to prevent alcohol-related problems. Such an effort must include education, mass media campaigns, increased availability of treatment programs, and more effective deterrence policies. It must also include public policy changes that take into account that the individual acts within a social, economic, and cultural environment that profoundly influences his or her choices. Such changes would include raising excise taxes on alcohol, putting warning labels on the bottles, and regulating the advertising. (It is estimated that increasing federal excise taxes on beer, the favorite alcohol beverage among youth, would reduce alcohol-related motor vehicle fatalities by 55 % among 18-to-20-year-old men and by 45% among 18-to-20-year-old women.[52])

Although, as discussed above, it may well be impossible to prove conclusively that alcohol advertising increases consumption, it quite clearly affects attitude formation and the internalization of social norms. The ads contribute to an environment of social acceptance of heavy drinking and denial of related problems. In addition, media dependence on alcohol advertising revenue discourages full and open discussion of the many problems associated with alcohol use. For these reasons alone, alcohol advertising should be controlled.

Many groups and individuals believe that the evidence calls for a total ban on alcohol advertising. Others are calling for a bill requiring equal time for counter-advertising and for a ban on all promotional activities of the alcohol industry on college campuses and on alcohol advertising aimed at young people. Dr. Otis R. Bowen, Secretary of Health and Human Services, recently called for restrictions of campus promotions for alcohol and on ads featuring risky activities (which are especially appealing to young people).[53] Among other things, this would leave college newspapers freer to provide accurate information about alcohol use and misuse without fear of offending their advertisers. It would also be an important first step in changing the unhealthy and dangerous norms that now prevail on our campuses and among young people throughout our society.

At the very least, it seems crucial that equivalent time be mandated for health messages about alcohol, if for no other reason than that consumers cannot get this information reliably in any other way from a media dependent upon alcohol advertising revenue. Funding for these messages could come from many sources, such as increased taxes on alcohol and a surcharge on alcohol industry ads. Billions of dollars could also be generated if alcohol advertising ceased to be a tax deduction for the industry.

We also need to investigate the extent to which the media are influenced by their dependence on alcohol advertising. We need a massive educational campaign designed to teach our children not only about alcohol and other drugs but also about advertising techniques. We must help our children become critical viewers and consumers.

We should restrict the placement of alcohol ads, e.g. not allow them to be directed at populations below the age of 21 or to be broadcast before 9PM. It is also important to regulate the content of alcohol ads. Some possibilities would include banning lifestyle ads, ads featuring risky activities, ads featuring athletes or celebrities, and ads exploiting women. The AAA report, Myths, Men & Beer, recommended, "At best, television beer commercials should be restricted to product identification. At the least, they should be prohibited from the use of images of automobiles, racetracks, speedboats, and other references to driving and speed in connection with their products." 54

Some of these restrictions are called for in the Wine Institute's Code of Advertising Standards. Unfortunately, the industry often fails to follow this code. For example, one of the guidelines states that "wine and wine cooler advertising by code subscribers shall not: Use music, language, gestures or cartoon characters specifically associated with or directed toward those below the legal drinking age." However, one wine cooler campaign features a talking polar bear (who, in one ad, is dressed as Santa Claus). Although the code says "Wine and wine cooler advertising by code subscribers shall not exploit the human form, feature provocative or enticing poses, nor be demeaning to any individual," 55 many wine ads continue to exploit women.

Rather than responding responsibly to the increasing concern about alcohol advertising, the industry often seems to be moving in just the opposite direction. The Distilled Spirits Council of the U.S. (DISCUS), the trade association of the liquor industry, recently revised its Code of Good Practice to permit the advertising of liquor-based coolers on television. Liquor producers are attempting to abandon voluntary guidelines and launch ad campaigns on radio and television.[56]

Unfortunately, government agencies have failed to effectively regulate alcohol advertising. The Bureau of Alcohol, Tobacco and Firearms permits the legislated policy of the federal and state governments to be undermined by alcohol advertisers. To correct this problem, it seems that Congress must either specifically legislate controls on alcohol advertising or transfer jurisdiction of this issue to an agency that will interpret federal laws for the protection of the public.

The Federal Trade Commission closed its investigation of suspected unfair advertising practices in the alcohol industry in 1982, five years after the Commission was denied industry-wide subpoena powers. Since that time, the FTC has failed to take any significant action to regulate the marketing of alcohol.

With the elimination of the Fairness Doctrine, the Federal Communications Commission has lost the basis it could have used to require equal time for health and safety warnings on radio and television. The FCC has shown no recent interest in making use of this power.

Congressional leadership is clearly called for. I respectfully suggest that the Congress:

1. Either ban alcohol advertising on radio and television or require that equal (or, at the very least, equivalent) time be furnished to responsible groups at no cost for the broadcast of health and safety warnings.

2. Amend the Alcohol Administration Act to specifically ban alcohol marketing directed at populations below the age of 21 or in environments likely to reach significant numbers of people below this age, to prevent the misleading impression that consumption of alcohol in this population is safe and legal. The Act should also be specifically amended to prohibit alcohol advertising which depicts any sports activity or the use of alcohol in any situation which requires unimpaired judgment and coordination, to avoid the misleading impression that the use of alcohol in such situations is safe.

3. Pass legislation currently before it (S.2047, H.R. 4441) mandating health and safety warning labels on alcoholic beverage containers. These same warnings should also be on print advertising (as is currently required for tobacco advertising).

4. Consider placing responsibility for regulating the alcohol industry with the Food and Drug Administration.

We urgently need a comprehensive national alcohol policy. These hearings under the leadership of this Committee are the most concerted attempt to review alcohol policy of the past eight years. I applaud this Committee for its work. We must, as a nation, work to reduce the stigma of alcoholism and reduce all alcohol-related problems. An important part of this work is to stop supporting the denial that is at the heart of the illness, both in the individual and in the society as a whole, the denial that alcohol advertising perpetuates and depends upon.

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LBIC
LICENSED BEVERAGE INFORMATION COUNCIL
1250 EYE STREET, N.W. • SUITE 900 • WASHINGTON, D.C. 20005 • (202) 628-3544

Statement of

John B. Burcham, Jr.
Chairman, Licensed Beverage
Information Council

Before the
Committee on Governmental Affairs
United States Senate

June 29, 1988

American Beverage Alcohol Association
Association of American Vintners
Distilled Spirits Council of the United States, Inc. (DISCUS)
National Association of Beverage Importers, Inc.
National Licensed Beverage Association
National Liquor Stores Association, Inc.
National Restaurant Association
The Beer Institute
Wine and Spirits Wholesalers of America, Inc.
Wine Institute

Ex officio: National Conference of State Liquor Administrators
Women's Association of Allied Beverage Industries

Thank you, Mr. Chairman, for this opportunity to report on the Licensed Beverage Information Council's support of extensive public education programs on alcoholism and other issues. I am John Burcham, chairman of the Council and executive director of the National Liquor Stores Association.

Ten industry trade associations formed the Licensed Beverage Information Council in 1979 and pledged its cooperation with the U.S. Department of Health & Human Services and the U.S. Department of Treasury. These associations represent those who produce, import, distribute and sell beer, wine and spirits in this country.

All of us in the alcohol beverage industry abhor any abuse of our products. This is the reason various industry associations and their members have supported programs aimed at reduction of alcohol abuse since the Repeal of National Prohibition. These varied and extensive programs are documented in appendices to this statement.

Essential to any "solution" to alcoholism and chronic problem drinking is to educate the public on the importance of intervention and treatment.

The LBIC is not an advocacy group and thus does not deal with political issues. Our purpose is to assist in communicating to the public and professionals information regarding problems such as alcoholism and chronic problem drinking.

The LBIC's public education efforts are directed to, among other things, drinking and pregnancy. In 1981 our program was broadened to include public education emphasis on alcoholism and chronic problem drinking. Subsequently the LBIC's charter was widened to include drunk driving and teenage drinking.

In conducting public education programs and education for medical professionals on these issues, the LBIC's efforts conform with recommendations made in the 1980 report issued by the U.S. Departments of Treasury and Health and Human Services, that concluded that education is the best method to inform the public. That report also commended the LBIC public and medical education program on drinking and pregnancy.

In 1981 officials at the U.S. Department of Health & Human Services approved and publicized the LBIC's expanded program platform statement.

That 1981 platform statement affirmed, in part, that:

* "Information communicated to the public should be based on objective appraisals of the latest scientific research findings. Personal opinion should be identified as such....

* "The medical profession has an ongoing need for current information and counsel from expert sources. The following principles are of underlying importance in educating the public on these complex problems:

"Alcoholism is an identifiable and treatable illness. Scientists believe physiological, genetic, and psychosocial factors are involved in the causation of this disease. There is no single alcoholic prototype.

"Allowing for semantic variations, the following terms are comparable: "excessive drinking," "problem drinking" and "abusive drinking." It is recognized that no two groups in the health education or alcoholism fields use the same language to communicate to the public about this subject.

"Since alcoholics are unlikely to heed fear appeals or cautionary slogans, affected individuals and their families should be motivated to get the professional treatment and support services they need. Here again is a message of hope.

"Due to the multiplicity of groups to be educated and the diversity of expertise involved, the LBIC will continue to sponsor a multi-group approach to the issues of drinking during pregnancy and the illness of alcoholism."

Since its inception the LBIC has followed a multi-media, multi-agency strategy with specific third-party groups. There is no single expert or group possessing all the expertise and outreach necessary for such programs. Projects supported by the LBIC are the ultimate responsibility of independent organizations specializing in research, education and treatment. They stand squarely behind the programs that they prepare, which LBIC support makes possible.

Prevention of alcohol abuse is a complex problem that requires multi-faceted solutions, since human behavior modification is far more difficult than simply saying "thou shall not."

The multi-media, multi-agency approach taken by LBIC is best shown in its support of programs on drinking and pregnancy. A special summary of the state of scientific knowledge was prepared by Jack H. Mendelson, M.D. of the Harvard Medical School. Dr. Mendelson's summary appeared in the Raleigh Hills Foundation's newsletter, Advances in Alcoholism, in the spring of 1979. This state of knowledge review, entitled "The Fetal Alcohol Syndrome," was mailed to 260,000 physicians that same year, with the cooperation of the American Medical Association, which provided LBIC with its mailing list for this purpose.

Under an LBIC grant, the Education Commission of the States (ECS) prepared a curriculum publication, "What Students Should Know About Drinking and Pregnancy." Their work was distributed to all 18,000 school districts in the nation, as well as to 14,000 post secondary schools in higher education and vocational training. In announcing the program at an ECS news conference in the spring of 1980, the Assistant Secretary of the U.S. Treasury Department, Richard J. Davis, stated that this cooperative program was the ideal that his department sought in early 1979 when Treasury called for a widespread public education campaign.

Using a unique survey method, the American Council on Alcoholism (ACA) prepared a publication providing answers to questions most often asked by the public in contacts with the ACA's national network of affiliated councils and hospitals. Over the years more than a million and a half copies have been distributed. The ACA publication, now in its fourth printing (including a version in Spanish), has been provided to 15,000 nursing course instructors and birth class directors.

LBIC has participated in the "Healthy Mothers, Healthy Babies" campaign from the time it was initiated in the fall of 1982 by Dr. Everett Koop, U.S. Surgeon General. During the initial phase of this program, which has been supported by a national coalition of medical and other health care provider associations, a series of six posters and information cards were distributed to 8,000 health clinics across this country. One of the posters, supported by an LBIC financial grant, addressed the topic of drinking and pregnancy, communicating to women the reported risks of excessive drinking.

LBIC has subsequently provided funds to the Healthy Mothers, Healthy Babies Coalition for (1) reprinting "The Community Connection," a 130-page guide to planning and organizing local coalitions to coordinate and stimulate the timely delivery of various health services to pregnant women; and (2) conducting regional workshops for state-level "HM, BB" coalitions, at which the latest research and medical information is provided.

For all of these LBIC cooperative activities with the "Healthy Mothers, Healthy Babies" campaign, LBIC was awarded special recognition awards co-signed by the U.S. Surgeon General in 1985 and again in 1986.

As indicated above, the LBIC program has followed a multi- media and multi-agency strategy (in cooperation with leading groups and experts). LBIC recognized from the beginning of its public education program planning in 1979 that no one group has the necessary expertise and outreach required to communicate with different groups of women in our diverse society. Accordingly, LBIC prepared a TV public service message in English and Spanish, to communicate directly with women of childbearing age. The messages were co-sponsored by the Bureau of Alcohol, Tobacco and Firearms, an agency of the U.S. Treasury Department. The spots were initially distributed to 900 network-affiliated and independent television stations around the country. ABC-TV aired the spots nationally, and return postcards from stations showed heavy and repeated use.

LBIC is most proud of its support for a pioneering clinical research, medical education, intervention and patient counseling program developed by the late Henry L. Rosett, M.D. and Lyn Weiner, M.P.H. of the Boston University School of Medicine. Since 1974 the Fetal Alcohol Education Program (FAEP) has developed research-validated methods to identify and intervene with women demonstrating a pattern of continuous excessive drinking.

The FAEP was awarded the technical exhibit prize by the American College of Obstetricians and Gynecologists for their professional display at an annual ACOG meeting in 1980. In addition the FAEP model has been adopted by the health care professions in Sweden.

Under a three-year grant provided by the Commonwealth of Massachusetts, the late Dr. Rosett and Professor Weiner conducted an extensive education program to train every health care professional in that state who could be reached through various seminars, workshops and continuing education provided by the hospitals for staff physicians, nurses and other relevant personnel.

Rosett and Weiner prepared more than 50 published articles and papers for presentation to professional audiences at various medical and health care conferences. Their 1984 book, Alcohol and the Fetus: A Clinical Perspective, has undergone several reprintings. It is a comprehensive review of more than 700 research projects worldwide on biomedical and behavioral aspects of drinking and pregnancy.

The current director of FAEP, Professor Weiner, and her colleagues are continuing their 15-year program of research, medical education and outreach with LBIC support. Two training films and two education packages, one for professionals and the other for use in community group settings, provide current information about drinking during pregnancy.

Continuing involvement in a special study group devoted to drinking during pregnancy, Professor Weiner participates with more than four dozen research and clinical specialists at the annual meeting of the Research Society on Alcoholism (RSA). The group holds workshops each year, to review the latest scientific research findings, meeting in session just prior to the RSA's annual medical/scientific meetings. Dr. Rosett was honored by the Society as its Research Scientist of the Year in 1984.

Professor Weiner and her associates are currently conducting follow-up studies on young children with birth defects, to learn how training and other rehabilitation efforts can ameliorate deficits in central nervous system function, learning and behavior problems.

Intervention and treatment are important facets of prevention. For example, employee assistance programs (EAP's) motivate workers to seek help at an early stage of their illness. LBIC has supported a public education program developed and conducted by the Association of Labor-Management Administrators and Consultants on Alcoholism, Inc. (ALMACA) to foster this goal.

ALMACA is the professional organization representing approximately 5,000 employee assistance program practitioners throughout American business and industry. This organization works in cooperation with government agencies, private employers, labor unions, scientific and educational institutions, as well as the media to inform the public about the EAP approach.

ALMACA's widely distributed EAP brochure reaches this range of new audiences with its message that alcoholism in the workplace is identifiable and treatable. Their publication emphasizes the benefits generated by soundly conceived EAP programs, how to help troubled employees and how to overcome their denials that a problem exists.

Many alcoholism field professionals believe that the EAP approach has been one of the most effective methods for reducing alcoholism and chronic problem drinking in this country.

In addition to being cost effective, EAP programs serve another vital purpose. As the ALMACA brochure says: "There is always the need to salvage people's lives in ways that reflect a very real compassion for loyal employees. These employees can be helped and they are worth helping."

ALMACA explained to a wide audience the variety of EAP structures available, suited to the varying size of companies and their work forces.

With up to 10,000 EAP's in existence today, the realization is growing that treatment which puts the alcoholic on the road to recovery will reduce medical care utilization from 26 to 69 percent, according to ALMACA.

Leading experts agree that alcoholism is a difficult but treatable health problem and that it affects entire families. With this in mind, the LBIC funded a program by the National Committee for Prevention for Child Abuse. NCPCA publishes materials that deal with such issues as child abuse prevention and parenting, since alcoholism can be a "family disease". This organization developed a book for kids on alcoholism and child abuse entitled "You're Not Alone"; the publication in English and Spanish versions is being distributed to 4th, 5th and 6th graders throughout the United States.

At a June 26, 1985 news conference launching the program, the following statement was made by the Commissioner of the HHS Administration for Children, Youth & Families:

> "As Commissioner of the Administration for Children, Youth and Families in Washington and --

more importantly, I think -- as a mother, I am deeply concerned about the 1.5 million children who suffer each year from the physical and mental abuse which is discussed in this new booklet, "You're Not Alone".

"Because it is written in a language young people can understand and relate to, "You're Not Alone" helps children to realize the abuse they have suffered is not their fault. It also helps children to see that they shouldn't blame themselves just because someone they loved and trusted hurt them.

"By encouraging projects like "You're Not Alone," we not only combat child abuse but, also, make an important investment in our future. It is one of the best investments I can think of -- one that will pay dividends in terms of human lives for generations to come....

"As we continue to explore new and innovative ways to rid this nation of child abuse, we will welcome such partnerships and will always be seeking new ones. We recognize that for programs to work well, they must be geared to the needs of local

> communities. Likewise, local communities must have a stake in them.
>
> "Once again, I want to express my appreciation to all those who have worked so hard to develop the booklet, "You're Not Alone." Your efforts serve as an inspiration to all of us who care about youngsters."

Leading experts also agree that trying to "inform" alcoholics is far less effective then offering messages of health and hope to their families, friends and employers. Thus, the LBIC public education efforts are intended to improve understanding and encourage intervention by those who are close to alcoholics.

An example of this is the American Council on Alcoholism's popular publication, "The Most Frequently Asked Questions About Alcoholism". This Q & A treatment responds to questions uncovered in a nationwide survey of ACA councils and assessing inquiries from those who are close to alcoholics. ACA's answers are based on existing research and other expert studies of the subject; the responses were put in non-technical language to enhance public understanding. Answered are such questions as: What is alcoholism? What are its symptoms? Is there such a thing as a weekend alcoholic? How can you help an alcoholic who does not want help? Why do alcoholics refuse to recognize their problems? How does an alcoholic recover from his complex illness?

ACA is a national health organization with the largest network of local alcoholism councils, as well as affiliations with alcoholism programs throughout the nation.

Another innovative project supported by the LBIC has been conducted by the Alcohol & Drug Problems Association of North America. ADPA's Working Women's Education Program Advisory Committee developed a new publication, "Some Thoughts About Drinking for Women in the Workplace". This publication has been widely distributed through ADPA members and affiliates, both private and public agencies. The emphasis is on alcoholism and problem drinking. ADPA separates myths from realities, particularly with a closer look to how men and women differ. Women usually become intoxicated with less alcohol than men for a variety of physiological reasons, including less body weight and body fluid. ADPA experts also emphasize that a woman's reactions to drinking may vary throughout the menstrual cycle at particular points in time.

More than half of all adult women in the U.S. are now in the work force. The drinking behavior of women is becoming more visible, providing opportunities for intervention when problems develop, as the ADPA publication points out.

ADPA goes on to say to working women: "If you have trouble limiting your own drinking to amounts and occasions which are trouble free...you may be one of those people who should not drink at all. As soon as you admit this to yourself and seek help to reduce the risk of becoming a casualty, the more you will enjoy the rest of your life.... Alcoholism is one of the few lifetime chronic illnesses known to medical science that is subject to permanent arrest."

An ADPA conference for women experts in research and treatment was transmitted to TV stations nationwide through closed circuit transmission funded by LBIC. The full film, together with the publication, are available for use in local communities.

Still another LBIC-supported project has focused on the important role played by the clergy in pastoral care of alcoholics. This effort by North Conway Institute (NCI) is based on many years of interfaith experience with the churchmen active in dealing with alcoholism problems. Their publication is titled "Pastoral Care of Families, Including Alcoholics and Problem Drinkers".

NCI, which was founded in 1951, promotes education for prevention of alcohol abuse and intervention/treatment for alcoholics.

In addition to working with churchmen who specialize in alcoholism-related problems, NCI has long collaborated with scientific and education experts to refine its knowledge base on these complex issues. As its publication makes clear, NCI's experience has led it to focus on families as much as on alcoholics for purposes of effective intervention at the earliest stage.

As NCI President Rev. David A. Works points out: "....I try to build a working relationship with, say the spouse of an alcoholic, to see what the strengths and weaknesses of the relationship are....You have to start out to be very accepting, not judgmental, even in difficult behavioral situations.... clergy and others who have been through this a number of times know how time-consuming and demanding this kind of pastoral care can be."

In concert with the views of research and other professional experts, the LBIC supports the cornerstone belief that problem drinking is intertwined with other issues, such as drunk driving. For example, Vincent Pisani, Ph.D. and traffic safety expert Charles Livingston have established that a major segment of the drunk driving population involves chronic problem drinkers who are repeat offenders. In cooperation with the National Commission Against Drunk Driving and Allstate Insurance Company, LBIC addressed this hard fact. An expert conference held in

Atlanta in 1986 has been summarized in an extensively circulated publication titled "Zeroing in on Repeat Offenders". Dr. Pisani's innovative intervention and treatment methods, systematically applied at the Central States Institute for Addictions, have been validated by stringent research and proven to work with the vast majority of problem drinkers in their care. This includes adolescents.

The LBIC's most publicly visible, extensive public education effort dealing with the drunk driving problem has been the "Friends Don't Let Friends Drive Drunk" campaign. Co-sponsored with the U.S. Department of Transportation (DOT) and the Outdoor Advertising Association, this multi- year program has resulted in more than 8,000 billboards posted nationwide. Repetitive broadcast of our radio and TV messages, by a majority of stations, was made possible via satellite transmission by the National Association of Broadcasters, an endorsement by the DOT Secretary Elizabeth Dole, and the cooperation of the National Commission Against Drunk Driving.

Benchmark indicators provided by sources such as HHS Centers for Disease Control, ALMACA and DOT show that real progress has been made in reducing alcohol abuse problems. We believe the LBIC has been among the many groups that have contributed to this beneficial outcome.

The issue of teenage drinking has been a topic of extended discussion and official concern for several generations. LBIC efforts are a part of the flood of print, audiovisual and other materials on this subject reaching the public -- reflecting widely differing viewpoints and conflicting approaches. We in the industry have, of course, long been mindful of teenage drinking problems, and active in efforts to reduce them. The study conducted by an NIAAA-funded ECS task force concluded in its 1978 report that the soundest remedial approach was to guide teenagers in their decisions about drinking and abstinence. Experts have noted that the vast bulk of adult-generated exhortations are largely ignored by teens. Many teenagers are quite familiar with alcohol beverages from family custom; under parental supervision in many cultures they partake of small amounts with meals and as part of family celebrations; teenagers are also familiar with sanctional usages in religious ceremonies and rituals.

LBIC provided grants to the American Driver and Traffic Safety Education Association (ADTSEA) and the American Council on Alcoholism (ACA) as part of the LBIC commitment to filling unmet needs.

In the area of driver education, ADTSEA felt that high school students, on the verge of getting a licensed privilege to drive, would be receptive to balanced education about alcohol in relation to the driving task. ADTSEA prepared two publications, one to guide teacher efforts in the classroom, and the other to promote thinking and responsible decision-making by students. More than 22,000 instructors and supervisory personnel (such as in state departments of education) have received these materials. ADTSEA's student publication, "Getting It Straight," has also been made available, since the time it was first offered for classroom use in 1985, in camera-ready, mass reproduction form in order to meet demand.

The American Council on Alcoholism, using its novel survey method with its network of affiliated councils across the country, assembled the most frequently asked (usually by adults) questions on teenage drinking. A pamphlet aimed primarily at parents provides informative responses. ACA is aware of the emotionalism surrounding drinking and alcohol abuse by teens, and that this often leads to unproductive communications between parents and their teenage children. The ACA publication is now in its second printing, since initial release and distribution in spring, 1986.

Those supporting the LBIC have been pleased with recognition accorded to its overall program.

President Reagan commended the LBIC in a 1983 radio broadcast for its "Friends Don't Let Friends Drive Drunk" campaign.

In a February 24, 1982 statement before the Senate Subcommittee on Alcoholism and Drug Abuse, the senior advisor on drug policy at the White House commended the LBIC effort.

On April 13, 1988 the LBIC program received a high rating from the World Health Organization's expert education consultant, who described our work and programs as "impressive". Also singled out in this commendation was the LBIC's method of working with leading health and education groups.

LBIC's co-sponsorship of the "Healthy Mothers/Healthy Babies" campaign has twice received HHS Special Recognition Awards co-signed by the U.S. Surgeon General in 1985 and 1986).

Within recent weeks the LBIC has been most gratified to learn it has twice won special recognition awards from President Reagan's Citation Program for Private Sector Initiatives. The LBIC qualified twice for the coveted C-Flag because of its co-sponsorship of the "Healthy Mothers, Healthy Babies" public education program on drinking and pregnancy, and its "Friends Don't Let Friends Drive Drunk" program.

The Citation Program was established in 1984 by the White House Office of Private Sector Initiatives to recognize extraordinary projects sponsored by businesses, trade associations and professional societies.

The LBIC model is being emulated in Holland and New Zealand, and is under study for possible adoption by industry groups in other countries.

Concurrent with the LBIC program and many years earlier, various industry associations and their members have played a substantive role in conducting and supporting programs designed to reduce alcohol abuse problems. We are not Johnny Come Latelies. Over the years, we have consistently fostered alcohol education awareness and made possible programs of quality research and prevention. These efforts over the years are documented in the attached appendices.

To sum up, the LBIC realizes the need to emphasize that excessive drinking is not acceptable behavior. The industry as a whole continues to support responsible, objective efforts to reduce and prevent alcoholism and excessive drinking problems.

THE SECRETARY OF HEALTH AND HUMAN SERVICES,
Washington, DC, August 3, 1987.

Hon. STROM THURMOND,
Subcommittee on Children, Family, Drug Abuse and Alcoholism, Committee on Labor and Human Resources, U.S. Senate, Washington, DC.

DEAR SENATOR THURMOND: Public Law 99-570, Section 4017 (the Anti-Drug Abuse Act of 1986), expressed the sense of the Senate that the Public Health Service should:

Assess the potential educational impact of health warning labels on containers of alcoholic beverages; and

Transmit a report to Congress on this topic, including findings on the impact and potential educational benefits of health warning labels and recommendations for specific label language.

We have completed the review of research literature on the effects of health warning labels on products currently labeled—tobacco, foods, drugs, and others. This review demonstrates that health warning labels do have the potential to affect consumer behavior, particularly in combination with other educational efforts. Although studies of the impact of health warning labels in "real world" situations have concluded they have an impact on behavior, as the report indicates, they "cannot be regarded as conclusive evidence that health warning labels are necessarily effective in all situations." As you are aware, this Department has used health warning labels and other educational approaches in the areas of tobacco, food, and drugs. The report of our review is enclosed.

Consumption of alcoholic beverages is associated with a wide range of serious health hazards including birth defects, impaired motor skills, adverse drug reactions, excess morbidity, and premature mortality due to liver damage, hypertension, and cancer among other illnesses. Nearly 100,000 deaths are attributed annually to alcohol consumption. In addition, the economic and social costs associated with alcohol use are staggering—in 1983, they reached $117 billion; by 1990, they are estimated to reach $136 billion; and, in 1995, to increase by an additional $14 billion to $150 billion. In brief, the magnitude and severity of these health effects argue for sustained and highly visible public health efforts.

I have informed the Secretary of the Treasury of our views and conclusions. We would be pleased to provide more information on the scientific evidence available on the health hazards of alcohol, and I would be happy to discuss our departmental approach with you further.

Sincerely,

OTIS R. BOWEN, M.D., *Secretary.*

CENTER FOR SCIENCE IN THE PUBLIC INTEREST,
Washington, DC, October 27, 1988.

Hon. JOHN GLENN,
U.S. Senate, Committee on Governmental Affairs, Washington, DC.

Attn: Dr. Eileen Choffnes.

DEAR SENATOR GLENN: Thank you for the opportunity to testify at your September hearings on preventing alcohol-related problems. During the questioning, you asked about sentencing in drinking and driving cases that included visits to the morgue. Enclosed please find two recent press clippings on such programs.

As you and the Committee on Governmental Affairs explore ways to reduce the tragedies caused by drinking and driving deaths and injuries, I hope that you will give special attention to the availability of alcoholic beverages and alcohol pricing policies. It simply does not make any sense to tax beer, for example, at such a low rate that consumers can now purchase a six-pack of beer for less than a six-pack of soda.

Beer is the alcoholic beverage of choice for under-age drinkers. According to research conducted by Henry Saffer and Michael Grossman of the National Bureau of Economic Research, if the federal tax on beer had been indexed to inflation since 1951, then the fatality rate for 18- to 20-year-olds would have been reduced by 15 percent during the period 1975–81.

Reducing drinking and driving fatalities and injuries will require a comprehensive strategy. While innovative penalty programs are explored, we must also take steps to change the environment in which alcohol-related problems occur. Thank you for your interest and concern.

Sincerely,

PATRICIA TAYLOR,
Director, Alcohol Policies Project.

Enclosure.

[From The New York Times National, Sept. 21, 1988]

DRUNKEN DRIVERS VISIT THE MORGUE

(By David S. Wilson)

SANTA ANA, CALIF. The nervous joking, what little there was, ended as the four young visitors to the coroner's office passed the body of a teen-age suicide victim on a wheeled table in the hallway. No one wanted to go first into the busy autopsy room.

"I'm glad I decided not to become a doctor," said one of the visitors.

The tour of the Orange County coroner's office was involuntary. The visitors were young men, 18 to 21 years of age, who, after drinking too much beer, had been arrested and convicted for the first time on charges of drunken driving.

In addition to their fines and probation, they had been sentenced to visit the coroner's office in what judges say is an attempt not so much to shock young offenders as to expose them to the fraility of human life.

The compulsory visit to the morgue, started three years ago by a judge in Sacramento, are evolving into a routine procedure in California, where they are being used by at least 24 judges in the state.

The program is also gaining the attention of courts in other states concerned about the high proportion of accidents caused by young drunken drivers. In December, for example, a similar sentencing plan will go into effect in Des Moines.

"Teen-agers think they're invincible," said Jo An F. Wheeler, coordinator of the Iowa program. "They don't need to be preached to, they need a dose of reality."

Such educational tours are not new. In New York and in many other places across the country, judges have sentenced adult drunken drivers to visit or even to work at morgues or emergency rooms as part of a community service requirement.

But the visits for young offenders are officially encouraged under a new California law that took effect this year. And, beginning next Jan. 1, an amendment to the law will allow people under 18 convicted of drunken driving to be sentenced to visit coroner's offices and emergency rooms at the discretion of judges.

The National Commission Against Drunk Driving, a nonprofit group, said people 15 to 20 years of age made up 8 percent of the nation's population last year but accounted for 17 percent of the drivers involved in fatal, alcohol-related traffic accidents.

According to California judges and those who have been sentenced to the visits, the visitation program works.

Judge Jeffrey L. Gunther of Sacramento Municipal Court began the sentencing program after visiting a hospital emergency room and seeing for himself the carnage caused by drunken driving.

He says only 6 of more than 400 youthful offenders who were given the special sentence in Sacramento in the last three years have been arrested again for drunken driving.

Those sentenced to the visits say they fear jail more, but looking at broken bodies and bleeding accident victims has a deeper impact.

"I basically learned that death is real," said a Sacramento man who went through the program two years ago. Like other youthful offenders, he asked not to be identified.

"I wouldn't even run a red light now, much less drink and drive," said one young man who participated in the monthly tour of the Orange County coroner's office recently.

The two-hour tours are given by Richard L. Rodriquez, senior deputy coroner. He tries to prepare the visitors for what they are about to see with a slide show of accidents and a talk on the results of drunken driving.

Judge Gunther stresses that judges must use care not only in choosing offenders to be sentenced for the visits, but also in picking those who guide the tours. "In the wrong hands these visits could harm a person," he said.

Judge Gunther and Anne Russell, national legislative coordinator for Mothers Against Drunk Driving, said no protests had been lodged against the coroner's office tours.

"No one's ever fainted or thrown up, but we try to handle the visitors with kid gloves," Mr. Rodriquez said. "The idea is to teach them not to be so selfish, to think twice about accident victims and their families."

[From Impact, October 1, 1988]

As of January 1, 1989, a new California law will allow those under the age of 18 to visit coroner's offices and emergency rooms as part of drunk driving sentences. The law complements another bill passed earlier this year which officially encourages judges to include a visit to the morgue as part of the overall drunk driving sentencing process.

According to published reports in West Orange County, CA, only one in 70 offenders who made such visits was arrested again, compared to the average of 30%–50% that are re-arrested after more traditional punishments. Beginning in December, judges in Des Moines, IA, will also be allowed to sentence young drunk driving offenders to visit morgues.

Testimony in Support of S. 2047 -- Legislation to Require Health and Safety Warning Labels on Alcoholic Beverages Containers

Statement of

Christine Lubinski, Washington Representative
National Council on Alcoholism

on behalf of

Coalition for Health and Safety Warnings on Alcoholic Beverages

before the

Consumer Subcommittee of the Senate Committee on Commerce, Science and Transportation

August 10, 1988

NCA is a private nonprofit health organization

My name is Christine Lubinski and I am the Washington Representative for the National Council on Alcoholism. The National Council on Alcoholism is the leading voluntary health organization working nationwide to prevent and reduce alcoholism, drug dependency and other alcohol and drug-related problems. NCA's two leading missions are public education and public advocacy. We have 190 state and local affiliate councils which provide information and referral services to families and individuals with alcohol and other drug problems. Many of these local councils conduct prevention and education programs and involve citizens in grassroots advocacy efforts.

Today, I am testifying both on behalf of the National Council on Alcoholism as well as on behalf of nearly 100 consumer, health, youth and religious organizations in support of S. 2047 and H.R. 4441 - bills which would mandate comprehensive health and safety warning labels on all alcoholic beverages. These organizations include the Center for Science in the Public Interest, the American Public Health Association, the Council on Alcohol Policy, the American Medical Association, Mothers Against Drunk Driving, the National Federation of Parents for Drug-Free Youth, the Consumer Federation of America, the National Perinatal Association and a great many others, including several of the other organizations represented here today. This coalition, which represents the views of hundreds of thousands of Americans, perceives health and safety warning labels on all alcoholic beverages as one important component of a comprehensive strategy to address alcohol problems in American society.

Warning labels will not end alcohol problems. They will provide Americans with important information about the products they are consuming and will notify the public that alcohol is a potentially dangerous drug. Warning labels will not eliminate or even necessarily reduce alcohol consumption. They will alert consumers of alcoholic beverages of specific health and safety risks attendant on alcohol use.

Legislative History of Warning Labels

The Congress and the Executive Branch have deliberated the issue of mandating health warning labels on alcoholic beverages for over ten years. On November 15, 1977, FDA Commissioner Donald Kennedy urged BATF to require health warning labels on alcoholic beverages which would outline the risks of birth defects from alcohol consumption during pregnancy. Although BATF concluded that there was sufficient evidence to require further action by industry and government, it postponed action on the issue, pending a public information campaign. On January 31, 1978, the Senate Subcommittee on Alcoholism and Drug Abuse held a hearing on "Alcohol Labeling and Fetal Alcohol Syndrome." Warning labels were supported by members of Congress, the Administrator of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) and the Commissioner of Food and Drug Administration (FDA), among others.

On May 7, 1979, the Senate passed by voice vote an amendment offered by Senator Strom Thurmond to require beverages containing more than 24 percent alcohol by volume to bear the following warning on their labels -- "Caution: Consumption of alcoholic beverages may be hazardous to your health."

In the meantime, Senator Donald Riegle, Chairman of the Senate Subcommittee on Alcoholism and Drug Abuse solicited alcoholism and drug abuse field groups and the general public for views on health warning labels on alcoholic beverages. A subcommittee staff report was released which summarized the responses to the Riegle questions. Of the more than 250 responses, those favoring warning labels outnumbered those in opposition by better than two to one. In September of 1979, the Subcommittee held the second Congressional hearings on health warning labels on alcoholic beverages.

Although warning labels had been endorsed by the Department of HEW, the Thurmond amendment was dropped in conference and replaced by a mandated study to be conducted by the Departments of HHS and Treasury on the Health Hazards Associated with Alcohol and Methods to Inform the General Public of These Hazards. This report is still considered a valuable resource because of its meticulous documentation of the various health and safety risks attendant on alcohol use and the serious gaps in public knowledge regarding these hazards. What was and is less valuable about this report was its conclusion -- that warning labels, including one to warn of the risks of drinking during pregnancy, were premature. This conclusion, from a document whose content seemed to be moving towards a very different recommendation, was so controversial that it was issued with an unprecedented Carter White House disclaimer which stated the support of the White House for warning labels.

Federal attention again turned to health risks associated with alcohol use in July, 1981, when the Surgeon General issued the first and only advisory to date regarding alcohol and health which alerts pregnant women and women considering pregnancy to abstain from alcoholic beverages and to be aware of the alcohol content of food and drugs. On September 21, 1982, Senator Gordon Humphrey, Chairman of the Senate Subcommittee on Alcoholism and Drug Abuse, held a hearing on alcohol consumption during pregnancy. Testimony offered by NCA, the American Medical Society on Alcoholism and the Chairman of the Alcoholism Panel of the American Medical

Association reiterated the need for health warning labels on alcoholic beverages about the risks of drinking during pregnancy.

Senator Thurmond continued to introduce warning label legislation in succeeding sessions of Congress. On May 20, 1986, Senators Thurmond, Kennedy and Hatch successfully amended the reauthorization of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in the Senate Labor & Human Resources Committee to require rotating health warning labels on alcoholic beverages. This bill-- which was similar to legislation now pending -- would have required labels on the dangers of drinking during pregnancy, drinking and driving, the risks of drinking while taking other drugs, and the links between alcohol consumption and cancers, hypertension and liver disease. This bill departed from previous labeling legislation both in the specificity of the labels and in its inclusion of all alcoholic beverages under the labeling mandate. The warning label bill languished on the Senate calendar and died at the end of the 99th Congress.

A Sense of the Senate Resolution contained in the Anti-Drug Abuse Act of 1986 requested a study from the Public

Health Service on the efficacy of warning labels and recommendations for their specific wording. A Review of the Research Literature on the Effects of Health Warning Labels was released to Congress on August 3, 1987. The findings indicate that health warning labels can affect consumer behavior, provided they are appropriately designed and executed. The report also points out the importance of reinforcing warning labels with other public education strategies.

In the 100th Congress, warning label legislation has been introduced in both Houses of Congress by Senator Strom Thurmond and Representative John Conyers, Jr. S. 2047 and H.R. 4441 would require five rotating warning labels on all alcoholic beverages including a label which would warn that alcohol is a drug and may be addictive.

Today's hearings are the fourth to be held by the United States Congress exploring the need and the efficacy for labels on alcohol. Two major government reports have been issued and a third is in progress. Secretary of Health and Human Services Otis Bowen has expressed his personal support for warning labels before Senator Glenn's Committee on Governmental Affairs this summer and the White House Conference for a Drug Free America has specifically called for health warning labels on alcohol in its final report. We are in the midst of a national mobilization to address the nation's drug problem. Appropriate federal regulation of the nation's favorite legal drug, alcohol, is in order. Enactment of legislation mandating rotating health and safety warning labels on all alcoholic beverages is long overdue.

The Case for Health Warning Labels on Alcoholic Beverages

Alcohol is the most widely available and the most destructive drug in America. Of the approximately 110 million adult drinkers in 1985, 10.5 million were alcoholics. Another 7.2 million adults experienced at least one serious consequence of alcohol use in the preceding year. For every alcoholic or problem drinker, another four people close to the drinker suffer negative effects. As many as one American in every three says an alcohol-related problem has caused trouble in his or her family.

The adverse economic impact of alcoholism and other alcohol-related problems is nearly $120 billion per year; there are almost 100,000 deaths from alcohol-related causes. Fetal Alcohol Syndrome is among the top three leading known causes of birth defects with accompanying mental retardation, and the only preventable one among the top three - preventable by not drinking. Brain damage by alcohol is second to Alzheimer's disease as a known cause of mental deterioration in adults. Alcohol contributes to other chronic illnesses, including cardiac myopathy, hypertension, pneumenia, and several types of cancers. Even light drinkers have doubled their risk of hemorrhagic stroke compared to abstainers.

In the just released federal report, The Surgeon General's Report on Nutrition and Health, alcohol is identified as one of five areas of recommendations for most people. The alcohol recommendations include a directive to limit alcohol intake to no more than two drinks a day and guidelines to avoid alcohol when driving, operating machinery, taking medication, during pregnancy and when engaging in any other activity requiring judgement. The report also states that if health labeling on alcohol is required, labels should include "information warning of hazards to the developing fetus as well as of other health hazards associated with alcohol consumption abuse (p. 661)."

The cost of alcohol related problems to our society is enormous. In 1987, the U.S. spent almost $500 billion on health care. Almost $100 billion, or 20% of these hospital care expenditures were for alcohol related problems. In one study conducted by NIAAA between 1980 and 1983, it was found that alcoholic families were found to use health care services and incur medical costs at nearly twice the rate of similar, non-alcoholic, families.

Alcohol remains the most widely used drug among American youth. Although young people may drink less regularly than older people, they tend to consume large quantities of alcohol and are more likely to become intoxicated. In 1986, an estimated 4.6 million adolescents aged 14 through 17-one in every three-experienced negative consequences of alcohol use, such as poor school performance, trouble with parents or involvement with law enforcement personnel. Recent surveys indicate the first drinking experience today usually occurs around age 12, in contrast to ages 13-14 in the 1940's and 1950's. It is no longer unusual for 10-12 year olds to have serious alcohol problems.

Our children do not identify alcohol as a drug. A 1987 Weekly Reader National Survey on Drugs and Drinking indicated that only 50 percent of fourth graders know that beer, wine or liquor is a drug, compared to 87 percent who know that marijuana is a drug.

And while adults may know that alcohol is a drug and can cause problems, studies indicate that the American public does not have information about the specific risks associated with alcohol consumption. For instance, while 90 percent of the public is aware that drinking during pregnancy may damage the fetus, in one study, one third of the women interviewed believed that an average daily consumption of more than three drinks was safe during pregnancy. A 1985 government survey found that only 57 percent of Americans of all ages had heard of the Fetal Alcohol Syndrome. A number of recent studies have strongly supported an association between alcohol consumption and breast cancer in women. Moreover, studies suggesting some protective influence of moderate alcohol consumption by women for cardiovascular disease found positive associations between alcohol consumption and stroke and hypertension in females.

A recent report from the National Center for Health Statistics pointed out that Americans are less knowledgeable about the adverse effects of alcohol on health (with the exception of cirrhosis of the liver) than they are about the harmful effects of smoking. Only one in three of those surveyed knew that alcohol was associated with cancers of the throat and mouth.

No one can argue that consumption of alcohol has the potential to pose serious threats to the health and welfare of the American people. Alcohol is a drug which should be used with caution. It is a particularly dangerous product for pregnant women, youth, individuals who are taking medication, drivers, children of alcoholics and recovered alcoholics.

Yet, alcohol continues to be exempted from a number of key consumer information strategies, including content and health warning labels. Numerous consumer products bear health warning labels including: cigarettes, smokeless tobacco, over-the-counter medications, aspirin, prescription drugs and products containing saccharin. Warning labels on these products offer consumers concrete information about risks associated with these products which they can then apply to their own health and environmental situations. Labels recommending avoidance of certain products when pregnant or when driving or operating machinery are commonplace on many products found in the local grocery or drugstore.

None of these products is responsible for the massive societal, health and economic damage as that caused by the use of alcohol. Ironically, the recommendation to simply extend this basic and low-cost public information initiative to alcoholic beverages elicits cries of prohibition from the alcohol beverage industry and its surrogates -- the only visible opposition to this initiative. Industry advocates go on to express paternalistic concerns about frightening the so called "moderate drinking majority." Such charges are totally unfounded. Neither NCA nor the overwhelming majority of coalition members have any interest in banning alcoholic beverages. And American consumers have clearly demonstrated a level of intelligence and thoughtfulness necessary to read a cautionary label and to respond accordingly. Warning labels do nothing to inhibit the right of consumers to choose to drink alcoholic beverages. Labels will only help to ensure that those choices are informed ones.

Currently, the nation's $75 billion a year alcoholic beverage industry has a corner on the alcohol information market. The industry spends over $2 billion a year educating consumers about the benefits of alcohol use. Alcohol marketing and advertising provides the single greatest source of alcohol education for American children. Our children will see close to 100,00 television commercials for beer alone by the time they are eighteen. While prevention and education programs in the schools and in our communities can make a difference, they cannot compete with the powerful and seductive influence of advertising which associates alcohol use with beauty, economic power, sexual fantasies and athletic achievement. In such an environment, it is no wonder that American youth become confused by say no to drug messages and frequently are not aware that alcohol is a drug.

Health warning labels will complement other prevention and education initiatives, including school-based curricula and public service announcements. They will institutionalize public health messages about alcohol use by placing this information constantly before the public eye on bottles and containers.

The experience with cigarette labeling indicates that the public is responsive to information detailing specific health risks. A 1981 Staff Report on the Cigarette Advertising Investigation, prepared by the Federal Trade Commission, noted that consumers were interested in more information about specific health hazards of smoking, even though their general awareness regarding smoking was high. Groups cited as particularly vulnerable included teenagers, pregnant women and persons with pre-existing medical conditions which are aggravated by smoking. These would be prime audiences for the alcohol-related health and safety warning labels.

Warning labels will provide important information for individuals who do not have access to medical care and who therefore, cannot rely on medical professionals to educate them about risks associated with alcohol consumption. This is particularly important for pregnant women who may not receive prenatal care until very late in their pregnancies.
A warning which carries the Surgeon General's advisory will formally and publicly establish abstinence from alcohol as the safest course of action during pregnancy.

Warning labels will help to set the record straight for youth who often do not consider alcohol to be a drug. They will help to counter the mixed messages youth often receive from adults -- the all too common picture of an adult with a drink in his or her hand warning about the dangers of "drugs". Moreover, S. 2047 would alert and hopefully curtail the all too dangerous youthful practice of combining alcohol with other drugs.

Warning labels will serve as an educational tool for families of problem drinkers and alcoholics. Many families do not understand that alcohol can be an addictive drug and that for the alcoholic, drinking must stop before any other change can occur. This type of education is particularly important since families can be instrumental in getting alcoholics to seek help.

Finally, and perhaps most importantly, warning labels will serve as a catalyst to open up the public information channels about alcohol. The pervasiveness of alcohol in our society and the ubiquitous alcohol ads have served to numb the American public to the magnitude of alcohol problems in our nation. The national "war on drugs" has all too often excluded alcohol in the rhetoric and in the programming.

Bipartisan and Grass Roots Support for Alcohol Labeling

The American leadership and general public support a warning label requirement. A 1984 Roper survey of alcohol problems reported that 64 percent of business, government, military and other leaders endorsed mandatory health warning labels and 68 percent of the general public agrees. According to a 1986 Gallup poll 8 persons in 10 or 79 percent of the general public support warning labels. A May, 1988 survey of physicians conducted by the American Medical Association found four-fifths of physicians interviewed, 82 per cent, supporting federal legislation to mandate health and safety warning labels on alcoholic beverage containers similar to those found on cigarette packages.

Support for labeling is bipartisan. American leaders in support of labeling include former First Lady Betty Ford, former Senator Harold Hughes and the Reverend Jesse Jackson. Senator Strom Thurmond and Representative John Conyers have come together on this issue. Warning label legislation offers the United States Congress an opportunity to contribute positively to the war on drugs without spending an additional dollar of the taxpayers' money.

Local communities and states have attempted to fill the vacuum in federal leadership in this area by enacting their own alcohol warning initiatives. New York City, Washington, D.C., Philadelphia, Los Angeles, and San Diego and some two dozen other cities and localities have enacted ordinances requiring posters at points of purchase for alcoholic beverages warning of the dangers of drinking during pregnancy. Warning label legislation, similar to S. 2047, has been introduced in the state legislatures of California, Pennsylvania, New Jersey, Florida and Massachusetts. These efforts are important and in communities where fetal alcohol syndrome warning signs have been posted, the increase in public awareness has been measurable. But alcohol problems are problems of national proportions which go well beyond state lines. One's level of knowledge about risks associated with alcohol use should not depend on where one lives in the country. Warning signs, while effective, only alert those consumers who purchase their own alcoholic beverages and enforcing sign ordinances is a mammoth task. States only have the authority to require warning labels on alcoholic beverages produced within the state borders. Federal action is required if uniform messages about health and safety risks associated with alcohol use are to reach every American consumer.

Just as states and communities have sought to respond to the need for health warnings to the public about alcohol, so has the judicial system become involved. There are now a number of serious product liability suits pending against alcohol producers for failure to warn. In Seattle, Washington, four fetal alcohol syndrome children and their families are suing alcohol producers for failure to warn of the risks of drinking during pregnancy. In Pennsylvania, the wife of a young man who died of severe pancreatitis after drinking 2-3 beers a day for a period of years has a major beer producer in court. Ameliorative Congressional action now to require warning labels on all alcoholic beverages will help to prevent additional needless alcohol-related tragedies from occurring simply because the consumers did not know and a multi-billion industry did not choose to warn.

Alcohol problems are complex and pervasive and a significant reduction in the social and economic toll of alcohol to the nation will require a comprehensive plan and years of concerted effort among all sectors of our society. Warning labels on alcoholic beverages are only one critical component of that plan. It is unclear how much of an impact warning labels will have on actual drinking behavior. We don't know until we try. Decisions about drinking will still rest ultimately with the alcohol consumer. But we do know that the federal government has a responsibility to protect the public health. And we do know that consumers have a right to know about the health and safety risks associated with legal products that they purchase and consume.

This Committee has the opportunity to make a valuable and cost-effective contribution to our national commitment to reduce drug problems in America. On behalf of the 100 organizations involved in the Coalition for Health and Safety Warning Labels on Alcoholic Beverages, I urge you to ensure that another session of Congress does not end without the enactment of legislation mandating health and safety warning labels on every bottle and container of alcoholic beverages produced in America.

A National Comparison
of
Public and Private Sector
Alcoholism Treatment Delivery System Characteristics

Statement for the Record
Committee on Governmental Affairs
United States Senate
Senator John Glenn, Chairman
June 16, 1988

by
Harold T. Yahr, Ph.D.,
Division of Biometry and Epidemiology
National Institute on Alcohol Abuse and Alcoholism

Mr. Chairman and members of the Committee, thank you for the opportunity to submit this statement for the record. This statement summarizes the salient points of my recent study entitled "A National Comparison of Public and Private Sector Alcoholism Treatment Delivery System Characteristics" as requested in your letter of May 26, 1988.

In recent years, in response to the increasing number of privately owned for-profit hospitals nationally and their competition with nonprofit hospitals for resources and patients, a number of studies comparing these institutions, primarily in regard to economic performance, have been reported in the literature. Most studies found that for-profit hospitals charge more than the nonprofit ones for providing similar services.

In the alcoholism treatment field, a great deal of concern has been voiced about the growth of the for-profit sector and its competition with the nonprofit sector for clients and resources. A related question that is raised more and more often is whether the field is developing into two alcoholism treatment delivery systems one public, the other private, and, if so, what the consequences are for the provision of treatment, particularly for the economically disadvantaged. Systematic empirical comparisons of the for-profit and nonprofit, or the public and private, sectors in regard to the economic status of clients served, types of care provided and treatment settings are absent from the literature. These comparisons assume particular importance in light of the mounting research evidence that, for most clients, social-setting detoxification, outpatient care and nonhospital-based care are at least as effective, but substantially less costly, than either medical model detoxification, inpatient care or hospital-based care.

The primary purpose of this study was to investigate the question of the existence nationally, of separate public- and private- sector alcoholism treatment delivery systems in regard to the economic status of clients served and the treatment settings and types of care provided. In addition, the distribution of the nation's alcoholism treatment units among the public and private ownership sectors and ownership trends were investigated.

METHOD

DATA COLLECTION

This study is based on data from national census surveys of alcoholism, drug abuse and combined alcoholism and drug abuse treatment units conducted for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) in 1979, 1980, 1982 and 1984. All units that were known to exist by each State alcohol and drug abuse authority, NIAAA, NIDA, the Veterans' Administration, the Administrative Office of the United States Courts and the Federal Prison System were requested to respond to a self-administered questionnaire. Only data pertaining to alcoholism and combined alcoholism and drug abuse treatment units were included in the present study. The number of treatment units that responded and the treatment unit response rates were: 1979, 4,219 units (93%); 1980, 4,465 units (92%); and 1982, 4,233 units (90%). In 1984, 6,963 treatment units responded. The treatment unit response rate for the 1984 survey was not determined; however, the response rate for all alcoholism, drug abuse and combined alcoholism and drug abuse service units was 90%.

State alcoholism and drug abuse agencies were the primary sources for identifying treatment units. Privately owned units that did not receive funds from these agencies, or that did not require State certification, were more likely than others not to be known by the State agencies and therefore, to have been underrepresented. In 1984, an outreach effort was made to identify units that might otherwise not have been included in the survey. This effort is likely to have resulted in the inclusion of more otherwise unidentified units in the private sector than those in the public sector. The comparison of alcoholism treatment delivery system characteristics associated with public-and private-sector treatment unit ownership was based on data from the 1982 survey, and the investigation of ownership trends was based on data from all four surveys. It should be noted that the outreach effort in 1984 is likely to have resulted in a greater percentage increase in number of units in all ownership sectors than would have occurred without the effort, and that increase is likely to have been greater for the private, particularly the for-profit, than for the public sector.

STUDY VARIABLES

In 1982 there were 295 for-profit treatment units which represented 7% of the total number of units nationwide. The number of units in the other ownership categories and the percentages of the total they represented were non-profit, 2,769 units or 65.4%; State-local, 964 (22.8%); and Federal, 205 (4.8%). The majority of units in both the for-profit and nonprofit sectors were owned by corporations. In the for-profit category corporations owned 76.9%; partnerships, 10.5% and individuals, 12.5%. In the nonprofit category corporations owned 86.5%; church related, 6.4%; and other, 7.2%. The largest percentage of State-local units were county-owned, 41.6%; followed by State ownership, 36.5%; city, 8.2%; city-county, 2.9%; hospital district, 1.7%; and other substate, 9.1%. The highest percentage of Federal units were Veterans Administration units, 49%; followed by Armed Forces, 19.6%; Public Health Service, 12.3%; and the Federal Prison System, 5.9%. The subcategory "other Federal agencies" accounted for 13.2% of the Federal units.

The treatment delivery system characteristics included in the study are: type of care provided, treatment unit setting, the provision of specialized programs, and the residence and economic status of the principal population served by the unit.

OWNERSHIP PROFILES

In order to highlight the service delivery system characteristics associated with each category of treatment unit ownership relative to the other categories and to facilitate their comparison, ownership profiles were constructed based on 14 subcategories of the aforementioned delivery system characteristics. Each of the profiles was also compared to an hypothesized profile, based on the 14 subcategories. This hypothesized profile conforms to perceptions drawn from the literature of characteristics of the private sector, generally, or the private for-profit sector, specifically, i.e. service to clients at higher economic levels and the provision of relatively expensive medical model, inpatient and hospital-based services.

In order to compare the ownership profiles to the hypothesized profile, difference scores were constructed. The difference score for each profile reflects the number and magnitude of the difference between it and the hypothesized profile. If a profile was identical to the hypothesized profile its score would be zero percent; on the other hand, if a profile was totally dissimilar its score would be 100 percent. Whether or not there are separate or distinct service systems would be indicated by the extent of the differences, if any, among the profile scores.

FINDINGS

The for-profit profile had a score of 18% and the Federal profile was 36%. In contrast, the State-local profile score was 86% and the nonprofit profile score was 75%. The results of the analysis support the conclusion that two separate systems of treatment delivery existed, nationally, during the study period. One of the systems, which closely resembled the hypothesized profile, characterized treatment delivery in the for-profit sector and, to a lesser degree, the Federal sector. The other system closely resembled the inverse of the hypothesized profile, i.e., service to clients at lower economic levels and the provision of relatively inexpensive social-setting detoxication, outpatient care and treatment in nonhospital settings. This system characterized treatment delivery in the State-local sector and, to a somewhat lesser degree, the nonprofit sector.

In order to flesh out the results of this analysis, it is useful to compare the distributions of the treatment units within each of the ownership categories in regard to the delivery system characteristics.

TYPE OF CARE

The types of care investigated were the provision of medical model detoxification, social setting detoxification, inpatient care and outpatient care.

Medical model detoxification refers to the use of medication under the supervision of medical personnel to reduce systematically or eliminate the effects of alcohol on the body in a hospital or other 24 hour care facility. Social setting detoxification refers to the restoration of client sobriety, on a drug-free basis, in a specialized nonmedical facility by trained personnel with physician services available when required. Thirty-five point two percent of the for-profit and 24.4% of the Federal units provided medical model detoxification compared to 15.3% of the State-local and 12.2% of the non-profit units. Compared to other types of care, small percentages of units within each of the ownership sectors provided social setting detoxification. Federal and for-profit units were least likely to provide social-setting detoxification, 2.9% and 5.4% respectively compared to rates of 7.0% for State-local and 9.6% for nonprofits.

Inpatient care is an approach that provides, in a residential setting or hospital, a planned program of professionally directed evaluation, care, treatment or rehabilitation services for alcoholism. Outpatient care refers to evaluation and treatment, or assistance services, provided on a short-term basis to clients who reside elsewhere. Sixty one point five percent of Federal units and 44.1% of for-profit units provided inpatient care compared to 38.1% of nonprofits and 22.3% of State-local units. State-local units were the most likely to provide outpatient care (74.7%)

followed, respectively by Federal (73.2%), nonprofit (59.7%) and for-profit (48.8%) units.

TREATMENT UNIT SETTINGS

Federal and for-profit units were most likely to provide care in hospital settings, 51.7% and 41.4% respectively, compared to 19.3% of State-local and 12.4% of nonprofit units. In contrast, 87.6% of nonprofit and 80.7% of State-local units provided care in non-hospital settings (e.g. Community Mental Health Centers, halfway houses, and recovery homes) whereas, 58.6% of for-profit units and 48.3% of Federal units provided care in these settings.

SPECIALIZED PROGRAMS

State-local and nonprofit units were more likely to provide special programs for public inebriates, 15.3% and 13.3% respectively compared to 5.4% of Federal and 3.0% of for-profit units. Employee Assistance and Occupational Alcoholism Programs provide alcoholism services to those who are employed. Fifty, point two percent of Federal and 43% of for-profit units had Employee Assistance Programs compared to 28.9% of State-local and 26.2% of nonprofit units. Twenty two percent of for-profit and 22.0% of Federal compared to 12.2% of nonprofit and 11.1% of State-local units had Occupational Alcoholism Programs.

RESIDENCE OF PRINCIPAL POPULATION

The residences of the principal populations served by units were classified as inner city, rural, other urban and suburban. Inner city refers to the older and more densely populated area of a large city, usually housing a low-income population. Therefore, populations residing in the inner city were ranked at the lowest economic level. The other residences in increasing economic rank order were rural, other urban and suburban. The justification for these rankings is based, in part, on United States census data for 1982 regarding median population income. Fifty-four point four percent of State-local and 46.4 percent of nonprofit units served principal populations residing in the two lower income areas, i.e. inner city and rural. Forty point four percent of Federal and only 17.9% of for-profit units served principal populations residing in these areas.

TREATMENT UNIT OWNERSHIP TRENDS

The for-profit sector was the only one that increased in number of units between each of the four survey years. Furthermore, this sector had the greatest rate of increase between the survey years. For example, between 1980 and 1982 the for-profits increased by 19.0% compared to a 4.6% increase in the number of Federal units and decreases of 9.2% and 6.4% in the numbers of State-local and nonprofit units.

Between 1982 and 1984, all of the sectors increased. The for-profit sector increased by 188.5% followed respectively by the nonprofit sector, 56.2%, State-local sector, 51.3%, and the Federal sector, 35.1%. As has been pointed out, the relatively large rates of increase between 1982 and 1984 were to some unknown extent a result of the 1984 survey outreach effort. In addition, these increases were likely to have been greater for the private sector, particularly the private for-profit sector.

The changes in the percentages of the total number of units constituted by each ownership sector between survey years were also investigated. Overall, the changes were relatively small. The for-profit sector was the only one that increased between each of the years; from 4.7% of the total in 1979 to 12.3% in 1984. The State-local sector decreased in its percent of the total between each of the years, declining from 25.1% to 21.1%. The nonprofit sector, after a small increase between 1979 and 1980, declined from 66.3% of the total in 1980 to 62.6% in 1984. The Federal sector's share of the total fluctuated between 5.1% in 1979 to 4.0% in 1984.

IMPLICATIONS

If the following assumptions are made, the findings of this study have a number of implications for the delivery of alcoholism treatment nationally: (1) the relationships between treatment delivery system characteristics and sector ownership that were found to exist in 1982 will continue; and (2) the differential patterns of growth and decline of the treatment unit ownership sectors that were found to exist during the period from 1980 to 1984 will continue.

The major implications of the study are: (1) The proportion of the nation's treatment units that provide medical model detoxification or inpatient care or treatment in hospital settings will continue to increase, whereas the proportions providing social setting detoxification, or outpatient care or treatment in nonhospital settings will continue to decline. (2) The proportions of the nation's treatment units that serve clients at lower economic status levels will continue to decline, as evidenced by the following trends: decreasing proportions of units that serve inner-city and rural populations; increasing proportions of units that serve urban and suburban populations; decreasing proportions of units that provide public inebriate programs; and increasing proportions of units providing Employee Assistance and Occupational Alcoholism Programs that serve employed clients. It should be reiterated that although the for-profit ownership sector experienced the greatest increase by far in number of treatment units between 1982 and 1984, all sectors, increased in their number of treatment units during this period.

The aforementioned national trends are of particular importance in the light of mounting research evidence that, for most clients, social-setting detoxification, outpatient care and nonhospital-based care are at least as effective but substantially less costly than medical model detoxification, inpatient care and hospital-based care. These trends merit further monitoring. It is necessary to collect client/patient level data to provide more direct evidence of the socioeconomic level of those being treated in the various ownership sectors as well as to investigate the appropriateness of the treatment provided. The types of data required include: gender, age, race/ethnicity, income, social stability, substance abuse and treatment history, severity of impairment and psychiatric and physical comorbidities. Furthermore, research that investigates the cost, productivity, and effectiveness of treatment delivery as a function of public and private sector ownership is called for.

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Drug and
Alcohol
Service
Providers
Organization of
Pennsylvania

MARCH, 1988

Suite 111, HOST INN, 4751 Lindle Road, Harrisburg, Pennsylvania 17111

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GOVERNOR PROPOSES BUDGET

On 2/9/88, GOVERNOR ROBERT CASEY presented his $19.9 billion dollar budget proposal to the Pennsylvania Legislature.

The budget for fiscal year 1988-89 involves a 4% boost in overall spending.

The plan proposes no tax increases and emphasizes the following priorities: education, nutritional services for pregnant women and for children, expansions in day care, in medical care and programs to provide for clean water and proper sewage disposal.

A sampling of budget proposals includes:

-- $214 million increase for state aid to public schools.
-- $341 million for early childhood health and development.
-- $9.9 million increase for Medical Assistance coverage for children and pregnant women.
-- $10.8 million increase for the homeless.
-- A proposal to pay off the state's unemployment compensation debt.
-- $2.5 billion dollars over 25 years to fund clean water projects and sewage disposal facilities.

Presentation of the proposed revenue and spending plan for state and federal dollars is the opening move in the annual budget process.

The Pennsylvania House and Senate have begun formal deliberations on the budget. House and Senate budget hearings were held in February and March in the Capitol.

Like any other legislation, the Pennsylvania budget must be passed by both the Senate and House prior to reaching the Governor.

In recent years, after House and Senate debate, large numbers of amendments have been added to the budget bill on the floor of both Chambers.

The task of bringing the budget into balance and of making final decisions on the spending plan has been reached by leadership from both the House and Senate during Conference Committee deliberations.

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*** The source document for all state and federal budget projections appearing in this publication is the Governor's Executive Budget, 1988-89.**

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DEPARTMENT OF HEALTH
DRUG AND ALCOHOL BUDGET
(In Thousands)
PREVENTION, EDUCATION AND TREATMENT

Funding Source	Actual 1986-87	Available 1987-88	Governor's Proposed 1988-89	% Increase
FEDERAL				
Anti-Drug Abuse Act (ADA)	----	8,216	4,848	- 41%
Alcohol, Drug and Mental Health Block Grant (ADMHBG)				
Alcohol	4,433	4,515	4,815	+ 7%
Drug	6,490	6,609	6,927	+ 5%
High Risk Pilot	128	220	245	+ 11%
ADA add-on to ADMHBG	----	681	----	-100%
Treatment Street Crime	----	----	110	new
TASC	----	35	----	-100%
Drug Free Schools	----	560	----	-100%
TOTAL FEDERAL	11,051	20,836	16,945	- 19%
STATE				
Assistance to Drug and Alcohol Programs	30,876	31,527	32,127	+ 2%
State Store Transfer	----	453	342	- 24%
TOTAL STATE	30,876	31,980	32,469	+ 2%
FEDERAL AND STATE TOTALS	41,927	52,816	49,414	- 6%

DEPARTMENT OF HEALTH
DRUG AND ALCOHOL BUDGET
AT A GLANCE
(In Thousands)

Funding Source	Actual 1986-87	Available 1987-88	Governor's Proposed 1988-89	% Increase
State	30,876	31,527	32,127	+ 2%
Federal (Block Grant)				
Alcohol	4,433	4,515	4,815	+ 7%
Drug	6,490	6,609	6,927	+ 5%
High Risk	128	220	245	+11%
FEDERAL TOTALS	11,051	11,344	11,987	+ 6%
State & Federal TOTALS	41,927	42,871	44,114	+ 3%

* Not included in these figures are the Federal Anti-Drug Abuse monies and funds to be transferred from the State Stores.

PROPOSED BUDGET FOR DRUG AND ALCOHOL

STATE FUNDING

Under the 1988-89 budget as proposed by GOVERNOR CASEY, drug and alcohol prevention, education and treatment in the Department of Health would receive an increase of $600,000 in general revenues. (+2%)

A new source of state funding for drug and alcohol services became available in 1987. (See related story) These dollars represent 2% of the profits from the sale of liquor by the Liquor Control Board. These revenues are expected to decrease from $453 thousand to $342 thousand in 1988. (-24%)

Overall state support for drug and alcohol prevention, education and treatment services will increase from $31,980 million to $32,469 million or a 2% increase.

FEDERAL FUNDING

The Federal budget for drug and alcohol services has become increasingly complex.

Federal dollars available from the Alcohol, Drug and Mental Health Block Grant (ADMHBG), will increase from $11,344 million to $11,987 million. (+6%)

Funds available for treatment from the Federal Anti-Drug Abuse Act of 1987 (ADA) are projected to decrease from $8,897 million to $4,848 million. (-45%) An additional $681,000 added last year to the ADMH Block Grant from the Anti-Drug Abuse Act will not be renewed in the 1988-89 budget.

Funds available to the Health Department for Drug Free Schools under the Anti-Drug Act will decrease from $560 thousand to zero.

Overall Federal support for the Health Department's prevention, education and treatment effort is projected to decrease from $20,836 million to $16,945 million or a 19% decrease. The projected 45% reduction in the Anti-Drug Abuse commitment for treatment is the major source of the projected reductions.

STATE AND FEDERAL FUNDING

Considering state and federal projections from ALL sources, the Health Department's prevention, education, treatment budget is projected to decrease from $52,816 million in 1987-88 to $49,414 million in 1988-89 -- an overall decrease of 6%.

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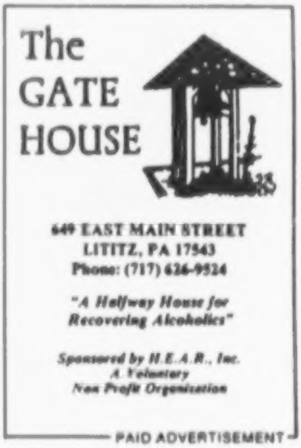
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OVERVIEW
ANTI-DRUG ABUSE ACT
MONIES TO PENNSYLVANIA *
(In Thousands)

Anti-Drug Abuse Act	**Estimates** 1987-88	Governor's **Proposed** 1988-89	% Increase
Commission on Crime and Delinquency	6,940	7,737	+11%
Drug Policy Council	140	144	+ 3%
Attorney General	641	848	+32%
Education	7,231	8,374	+16%
HEALTH DEPARTMENT	8,894	4,931	-45%
Probation and Parole	209	587	+180%
State Police	2,542	-0-	-100%

- Includes monies for administration and programs.
- Page A45, 1988-89 Governor's Executive Budget.

DRUG POLICY COUNCIL
(In Thousands)

Funding Source	Actual 1986-87	Available 1987-88	Governor's **Proposed** 1988-89	% Increase
FEDERAL Anti-Drug Abuse Act				
Local Law Enforcement	----	97	98	+ 1%
Special Programs/Drug Free Schools and Communities	----	43	46	+ 7%
TOTAL FEDERAL	----	140	144	+ 3%
STATE Drug Policy Council	----	84	91	+ 8%
TOTALS State and Federal	----	224	235	+ 5%

AIDS BUDGET
(In Thousands)

Funding Source	**Actual** **1986-87**	**Available** **1987-88**	**Governor's** **Proposed** **1988-89**	% Increase
STATE AIDS Education	117	350	350	0%
FEDERAL				
AIDS Surveillance	46	146	-0-	0%
PHHSBG * -- AIDS	-0-	600	400	-33%
Health Education	321	2,403	4,900	+104%
FEDERAL TOTAL	367	3,249	5,300	+ 63%
STATE & FEDERAL TOTAL	484	3,499	5,650	+ 61%

* Preventive Health and Health Services Block Grant

DEPARTMENT OF CORRECTIONS
(In Thousands)

Funding Source	Actual 1986-87	Available 1987-88	Governor's Proposed 1988-89	% Increase
FEDERAL Alcohol, Drug and Mental Health Block Grant Rehabilitation	110	110	110	+ 0%
Therapeutic Communities	----	237	579	+144%
Drug and Alcohol Rehabilitation	----	105	144	+ 37%
TOTALS	110	452	833	+ 84%

COMMISSION ON CRIME AND DELINQUENCY
(In Thousands)

Funding Source	Actual 1986-87	Available 1987-88	Governor's Proposed 1988-89	% Increase
FEDERAL Anti-Drug Abuse Act				
To Local Law Enforcement				
Administration	----	200	200	+ 0%
Local Law Enforcement	----	5,116	7,537	+ 47%
To State Law Enforcement				
Administration	----	121	----	-100%
State Law Enforcement	----	1,503	----	-100%
TOTALS	----	6,940	7,737	+ 11%

DEPARTMENT OF EDUCATION
(In Thousands)

Funding Source	Actual 1986-87	Available 1987-88	Governor's Proposed 1988-89	% Increase
Federal Anti-Drug Abuse Act				
Administration	----	506	680	+34%
Drug Free Schools and Communities	----	4,556	5,200	+14%
Special Drug Program	----	2,169	2,494	+15%
TOTALS	----	7,231	8,374	+16%

DRUG AND ALCOHOL FIVE YEAR SPENDING ESTIMATES

The Governor's Executive Budget for 1988-89 includes estimates of federal and state funding across a five year period. These numbers are estimates and are subject to revision as annual numbers become available.

Five Year Estimate
Drug and Alcohol Prevention and Treatment
(In Thousands)

Funding Source	Available 1987-88	Governors Proposed 1988-89	Estimated 1989-90	Estimated 1990-91	Estimated 1991-92	Estimated 1992-93	% Change 1988-89 to 1992-93
State	32,302	32,127	32,127	32,127	32,127	32,127	0
Federal	20,836	16,945	16,945	16,945	16,945	16,945	0
State Store Transfer	453	342	342	342	342	342	0
TOTALS	53,291	49,414	49,414	49,414	49,414	49,414	0

Five Year Estimate
Program Measures

	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	+/- %
PREVENTION							
Persons Viewing Films	110,000	110,000	120,000	120,000	125,000	125,000	+14%
Materials Distributed	493,000	540,000	560,000	580,000	600,000	600,000	+11%
School Personnel Trained/SAP	1,320	1,425	1,500	1,600	1,625	1,650	+16%
School Districts in SAP	83	108	133	158	183	208	+93%
TREATMENT							
Inpatient Programs Licensed/Approved Hospital	103	103	103	103	103	103	0%
Non-Hospital	133	140	146	153	159	165	+18%
Outpatient Licensed/Approved	316	321	324	326	336	334	+ 4%
Patients Enrolled Male	49,450	49,900	50,400	50,900	51,400	51,900	+ 4%
Female	17,340	17,401	17,511	17,555	17,611	17,668	+ 2%
Treatment Completed	23,600	24,050	24,500	25,000	25,500	26,000	+ 8%
Admission Primary Drug	26,393	25,612	25,845	26,055	27,202	27,410	+ 7%
Primary Alcohol	43,237	43,610	44,005	44,362	44,800	45,320	+ 4%

PENNSYLVANIA DRUG AND ALCOHOL BUDGET OVERVIEW 1977-1989
(In thousands)

Fiscal Year	77-78	78-79	79-80	80-81	*81-82*	82-83	83-84	84-85	85-86	Actual 86-87	Available 87-88	Governor's Proposed 88-89	% Increase 1977-89
Source of Funds:													
State *	17,990	19,000	21,100	21,100	21,531	23,500	24,414	26,911	29,118	30,876	31,527	32,127	+79%
Federal	12,401	11,200	9,501	11,088	11,199	13,421	13,979	11,663	11,590	11,051	11,344	11,987	- 3%
TOTALS	30,391	30,200	30,601	32,188	32,730	36,921	38,393	38,574	40,708	41,927	42,871	44,114	+45%

* Numbers are in thousands. Example: 1977-78 State funds are $17.990 million.

* Alcohol, Drug and Mental Health Block begins 1981-82.

* Figures do not include Federal Anti-Drug Abuse Act or State Store Transfer monies.

These figures are derived from Pennsylvania's budget documents. A more accurate funding picture must include the phasing out of $4 million in direct federal grants to drug and alcohol programs in the state when the Alcohol, Drug and Mental Health Block Grant was created. These funds did not pass through the Office of Drug and Alcohol Programs, nor did they come from the state legislature. For these reasons, this $4 million additional loss to Pennsylvania is not reflected in the state budget documents. A re-calculation of the Budget Overview with the $4 million loss generates the following figures:

(a) for 1977-1989 - 27% decrease in Federal funds to the drug and alcohol budget.
(b) for 1977-1989 - 79% increase in State funds to the drug and alcohol budget
(c) for 1977-1989 - 28% increase in total funds to the drug and alcohol budget

OVERALL BUDGET 1977-1989

1977-1989 - 28% increase in state and federal funds combined
1977-1987 - 80% increase in the Consumer Price Index

Comparison Figures - State Funds Only
(In thousands)

Fiscal Year	77-78	78-79	79-80	80-81	81-82	8[illegible]-83	83-84	84-85	85-86	Actual 86-87	Available 87-88	Governor's Proposed 88-89	% Increase 1977-89
Medical Assistance	334,300	580,153	629,924	702,257	741,487	77[illegible],534	900,359	982,826	1,073,273	1,116,949	1,161,688	1,260,659	+277%
Corrections	73,099	80,596	86,768	93,396	107,398	12[illegible],664	140,335	161,236	185,268	204,144	239,100	259,085	+254%
Program Funding Community MH/MR	121,426	176,040	175,671	196,596	222,544	24[illegible],431	261,970	260,148	297,049	326,723	369,634	386,377	+218%
Drug & Alcohol	17,990	19,000	21,100	21,100	21,531	2[illegible],500	24,414	26,911	29,118	30,876	31,527	32,127	+79%
State Store	---	---	---	---	---	---	---	---	---	---	453	342	+80%

The Drug and Alcohol Service Providers Organization of Pennsylvania (DASPOP) supports funding to other related areas. Comparison data is provided for background purposes only. The data makes the case that not all services are facing budgetary problems similar to drug and alcohol programs. As the charts reflect, Medical Assistance has averaged a 23% a year increase for the last 12 years, Corrections 21% and MH/MR 18%. Each of the services chosen for comparison has a high correlation to drug and alcohol abuse and addiction. Nonetheless, drug and alcohol has averaged less than a 7% a year increase in state funds over the last 12 years. If combined state and federal funds are considered, the increase in just over 2% (2.3) a year.

Review

A National Comparison of Public and Private Sector Alcoholism Treatment Delivery System Characteristics

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Running Title Page

Public/Private Sector Alcohol Treatment

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Alcoholism treatment delivery systems
Public/private sector alcohol treatment delivery systems
Alcohol treatment unit ownership growth patterns
For-profit sector alcoholism treatment delivery system characteristics
Private nonprofit sector alcoholism treatment delivery system characteristics
State/local alcoholism treatment delivery system characteristics
Federal alcoholism treatment delivery system characteristics

Harold T. Yahr, Ph.D.
A National Comparison of Public and Private
Sector Alcoholism Treatment Delivery
System Characteristics

Abstract

The primary purpose of this study was to investigate the question of the existence, nationally, of separate public and private sector alcoholism treatment delivery systems in regard to the economic status of clients served, types of care provided and treatment setting. The analyses was based on data from the 1982 National Federal Census Survey of Treatment units. Public and private sector profiles based on the aforementioned delivery system characteristics were constructed and compared. Each of the profiles was also compared to a hypothesized profile, based on perceptions drawn from the literature, of the characteristics of treatment delivery in the private sector, generally, or the private-for-profit sector, specifically. The results of the analysis support the conclusion that two separate systems of treatment delivery existed, nationally, during the study period. The distribution of the nation's alcoholism treatment units among the public and private ownership sectors and ownership trends were also investigated using data from National Federal census surveys conducted in 1979, 1980, 1987 and 1984. The future implications of the study findings are discussed.

Introduction

In recent years, in response to the increasing number of privately owned for-profit hospitals, nationally, and their competition with nonprofit hospitals for resources and patients, a number of studies comparing these institutions, primarily in regard to economic performance, have been reported in the literature. Most studies found that for-profits charge more than nonprofits for providing similar services (Lewin, 1981; Patterson and Katz, 1983; Lewin et. al., 1985). Sloan and Vraciu (1983) in their study of hospitals in Florida during the period from 1977 to 1981 found no differences between for-profit and nonprofit hospitals in regard to after tax profit margins.

In the alcoholism treatment field, a great deal of concern has been voiced about the growth of the for-profit sector and its competition with the nonprofit sector for clients and resources (Weisner and Room, 1984; Jacob, 1985). A related question increasingly raised is whether the field is developing into two alcoholism treatment delivery systems, one public, the other private, and, if so, what the consequences are, for the provision of treatment, particularly for the economically disadvantaged (Jacob, 1985). Weisner and Room, in their study of counties in California, found that private programs "were populated" by those who had private health insurance, whose employer would pay for their treatment or those who could afford to pay for the treatment (Weisner and Room, 1984). Weisner and Room (1984) maintain that the private alcohol treatment system has grown more in response to the need to fill hospital beds than to the demand for treatment (p. 177). Miller and Hester (1986) maintain that for-profit providers are the primary beneficiaries of impatient treatment (p.803). Systematic empirical comparisons of the for-profit and nonprofit or the public and private sectors in regard to the economic status of clients served, types of care provided and treatment settings are absent from the literature. This comparison assumes particular importance in the light of the mounting research evidence that, for most clients, social-setting detoxification, outpatient care and nonhospital-based care are at least as effective but substantially less costly than medical model detoxification, inpatient care and hospital-based care, respectively, (Emrick, 1975; Stinson, et.al., 1979; McCrady, et.al., 1986; Miller and Hester, 1986).

The primary purpose of this study was to investigate the question of the existence, nationally, of separate public and private sector alcoholism treatment delivery systems in regard to the economic status of clients served, and the aforementioned treatment settings and types of care provided. In addition, the distribution of the nation's alcoholism treatment units among the public and private ownership sectors and ownership trends were investigated.

METHOD

Sample

This study is based on data from national census surveys of alcoholism, drug abuse and combined alcoholism and drug abuse treatment units conducted for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) in 1979, 1980, 1982, and 1984. (U.S. Department of Health and Human Services; 1980, 1981, 1983; Reed and Sanchez, 1986). All units which were known to exist by each State alcohol and drug abuse authority, NIAAA, NIDA, the Veteran's Administration, the Administrative Office of the Courts and the Federal Prison System were requested to respond to a self-administered questionnaire. Only data pertaining to alcoholism and combined alcoholism and drug abuse treatment units were included in the present study. The number of treatment units which responded and the treatment unit response rates in 1979, 1980 and 1982 were 4219 (93%), 4465 (92%) and 4233 (90%) respectively. In 1984, 6963 treatment units responded. The treatment unit response rate for the 1984 survey was not determined, however, the response rate for all alcoholism, drug abuse and combined alcoholism and drug abuse service units was 90%.

State alcoholism and drug abuse agencies were the primary sources for identifying treatment units. Privately owned units which did not receive funds from these agencies, or which did not require State certification were more likely than others not to be known by the State agencies and, therefore, to have been underrepresented. In 1984, an outreach effort was made to identify units that might otherwise not have been included in the survey. This effort is likely to have resulted in the inclusion of a larger percentage of otherwise unidentified private sector than public sector units. The comparison of alcoholism treatment delivery system characteristics associated with public and private sector treatment unit ownership was based on data from the 1982 survey, and the investigation of ownership trends was based on data from all four surveys. The latter investigation had a greater probability of being subject to sample bias than the former because of the possible compounding of sample bias in each of the surveys. It should be noted that the outreach effort in 1984 is likely to have resulted in a greater percentage increase in number of units in all ownership sectors than would have occurred without the effort. In addition, the increase is likely to have been greater for the private than for the public sector.

Data Collection

During the 1979, 1980 and 1982 surveys, essentially the same information was requested from treatment units. All questionnaire items were structured. The 1984 survey questionnaire was a much shorter, modified version of the questionnaires used in the previous surveys. Treatment unit staff who were assigned to respond to the surveys were given training at regional workshops. All returned survey questionnaires were checked for item consistency and missing items, and efforts were made to obtain information to correct the deficiencies from the respondents.

Study Variables

Public and private sector alcoholism treatment unit ownership was treated as the independent variable in this study. Ownership was defined[1] as the type of organization legally responsible for the operation of the unit. The categories and subcategories of ownership are listed below:

1. For-profit: individual, partnership, corporation
2. Nonprofit: church related, nonprofit corporation, other nonprofit
3. State/local government: State government, county government, city government, city-county government, hospital district, other substate government
4. Federal government: U.S. Public Health Service, Armed Forces, Veteran's Administration, Federal Prison System, other Federal agencies.

The subcategories within each of the major categories were aggregated for the present analysis. Categories 1 and 2 constitute the private sector and categories 3 and 4 constitute the public sector. Alcoholism treatment delivery system characteristics were treated as dependent variables. The characteristics included in the study follow:

Type of care

1. Medical Model Detoxification

   The use of medication under the supervision of medical personnel to systematically reduce or eliminate the effects of alcohol on the body in a hospital or other 24 hour care facility.

2. Social Setting Detoxification

   Restoration of client sobriety, on a drug-free basis, in a specialized nonmedical facility by trained personnel with physician services available when required.

3. Inpatient care

   An approach which provides, in a residential setting or hospital, a planned program of professionally directed evaluation, care, treatment or rehabilitation services for alcoholism.

4. Outpatient care

   Evaluation and treatment, or assistance services, provided on a short-term basis to clients who reside elsewhere.

Specialized programs

1. Public inebriate
2. Employee Assistance Program
3. Occupational Alcoholism Program

Population served, i.e. the residence of the principal population served by the unit.

1. Inner City 1
2. Rural 2
3. Other urban 2
4. Suburban 1

Residence was also used as a surrogate measure of the economic status of the principal population served by the unit.[2] Inner city residence was ranked at the lowest economic level, followed in increasing rank order by rural, other urban and suburban residence respectively.

Treatment Unit Settings

1. Community mental health center
2. Mental/psychiatric hospital
3. General hospital including VA Hospital

4. Other specialized hospital
5. Correctional facility
6. Freestanding facility
7. Other

All of the hospital categories were combined for the present analysis.

Analysis

The data that this study was based on were considered to be census data, therefore, descriptive, rather than inferential statistics were utilized. The percentage rates of association between the treatment units within each ownership category and the categories of each of the dependent variables were compared. In order to highlight the alcoholism treatment service delivery system characteristics associated with each category of treatment unit ownership relative to the other categories and to facilitate their comparison, ownership profiles were constructed by the following method: The mean of the percentage rates of association of the treatment unit ownership categories in regard to the categories of each dependent variable were calculated in order to obtain unweighted averages. The percentage rate of association between each ownership category and each dependent variable category was, then, compared to the mean percentage rate. A criterion of ±5% was selected to define substantive significance.

Therefore, if the percentage rate of association between a given ownership category and a given dependent variable category was at least 5% greater than the mean rate, the percentage was considered to be "large" compared to the other ownership categories. Conversely, a percentage rate at least 5% smaller than the mean was considered to be "small".

Percentage rates between these values were considered of no substantive significance.[3] The ownership profiles are presented in Table 8.

Results

Treatment unit ownership

In 1982 there were 295 for-profit, 2769 nonprofit, 964 State/local and 204 Federal treatment units nationwide representing 7.0%, 65.4%, 22.8%, and 4.8% of the total, respectively. The distributions of units within the subcategories of each ownership sector are presented in Table 1. The majority of units in both the for-profit, 76.9% and nonprofit, 86.5%, sectors were corporations. The largest percentage of State/local units, 41.6%, were county owned, followed by State ownership, 36.5%. The percentage of units in the remaining State/local subcategories, i.e. city-county; hospital district and other substate ranged from 1.7 to 9.1%. The highest percentage of Federal units, 49.0%, were Veteran's Administration units, followed, in decreasing order; by Armed Forces, 19.6%, Public Health Service, 12.3%, and the Federal Prison System, 5.9%. The subcategory other Federal agencies accounted for 13.2% of the Federal units.

Type of care

As shown in Table 2, the for-profit sector included the highest percentage of units, 35.2%, which provided medical model detoxification, followed by the Federal sector, 24.4%. The State/local and nonprofit sectors had the lowest percentages of units, 15.3% and 12.2% respectively, providing this type of care. Compared to the other types of care, small percentages of units within each of the ownership sectors provided social setting detoxification, the rates ranged from a high of 9.6% of nonprofit units to a low of 2.9% of Federal units. Federal units provided inpatient care at the highest rate, 61.5%, followed in decreasing order by for-profit units, 44.1%, nonprofit units, 38.1%, and State/local units, 22.3%. State/local and Federal units provided outpatient services at the highest rates 74.7% and 73.2% respectively followed by nonprofit units, 59.7%. For-profit units provided outpatient services at the lowest rate, 48.8%.

Specialized Programs

For-profit and Federal units provided public inebriate programs at the lowest rates, 3.0% and 5.4% respectively compared to the nonprofit, 13.3%, and State/local, 15.3%, ownership sectors (Table 3). Federal units provided employee assistance programs at the highest rate, 50.2%, followed in decreasing order by for-profit, State/local and nonprofit units with rates of 43.0%, 28.9% and 26.2% respectively. For-profit and Federal units provided occupational alcoholism programs at the highest rates, 21.7% and 21.5% respectively compared to nonprofit and State/local units which provided these programs at the lowest rates, 12.2% and 11.1% respectively.

Residence of principal population (Economic status)

Nonprofit units served principal populations residing in inner cities, classified as the lowest economic status grouping in this study, at the highest rate, 20.4%, followed by Federal, 16.5%, State/local, 12.7%, and for-profit, 10.1%, units (Table 4). State/local units served principal populations residing in rural areas (second lowest economic status grouping) at the highest rate, 41.7%, followed by nonprofit and Federal units, 26.0% and 23.9% respectively, and for-profit units, 7.8%. Federal units served principal populations residing in other urban areas (second highest economic status grouping) at the highest rate, 45.3%, followed by for-profit, nonprofit, and State/local units with rates of 41.3%, 35.1% and 31.1% respectively. For-profit units had the highest rate of service, 40.6%, to principal populations residing in suburban areas (highest economic status grouping) compared to the other ownership sectors which served these populations at rates which ranged from 14.1% to 17.1%.

Treatment unit settings

The State/local ownership sector had the highest percentage of treatment units, 33.1%, located in community mental health center settings, followed by nonprofit units, 20.1%, and Federal and for-profit units, 3.4% and 2.7% respectively (Table 5). Over half, 51.7%, of Federal units and 41.4% of for-profit units were located in hospital settings. Substantially smaller percentages of State/local, 19.3%, and nonprofit units, 12.4%, were were located in these settings. Correctional facilities were the setting for 6.3% of Federal and 4.6% of State/local units; no for-profit and 0.4% of nonprofit units were located in these settings. Most nonprofit units, 53.2% were located in freestanding facility settings followed by for-profit units, 37.6%, and State/local and Federal units, 24.4% and 25.8% respectively. It was estimated that 90% of the units that selected the "other" treatment unit setting category were located in freestanding facility settings. These estimates were based on verification of a 10% sample of units that selected the "other" category. If this is assumed to be the case for each ownership sector, then 65.7% of nonprofit units were located in freestanding facility settings compared to 54.1%, 41.3% and 37.3% of for-profit, State/local and Federal units respectively.

Treatment unit ownership trends

The percent change in number of treatment units in each ownership sector between survey years is presented in Table 6. For-profits were the only sector which increased between each of the survey years. Furthermore, the for-profits had the greatest rate of increase between each of the survey years, having increased 24.6% between 1979 and 1980, 19.0% between 1980 and 1982 and 188.5% between 1982 and 1984. Non-profit units declined by 6.4% between 1980 and 1982, after having increased 8.2% between 1979 and 1980. Nonprofits had the second largest increase, 56.2%, between 1982 and 1984. State/local units declined between 1979 and 1980 and 1980 and 1982 by .7% and 9.2% respectively and then increased by 51.3% between 1982 and 1984. Federal units declined by 8.4% between 1979 and 1980, they then, increased between the three subsequent survey years by 4.6% and 35.1% respectively.

As shown in Table 7, for-profit units increased consistently as a percentage of the total number of units; from 4.7% in 1979 to 7.0% in 1982, they then, increased to 12.3% in 1984. During this time period, State/local units decreased consistently from 25.4% to 21.1% and Federal units remained relatively stable, contributing 4.0% to 5.1% of the total. Nonprofit units increased from 64.8% of the total in 1979 to 66.3% in 1980 and then declined consistently to 62.6% in 1984.

Ownership profiles

Profiles of the treatment unit ownership sectors, which were constructed by the method described in the Analysis Section, are presented in Table 8 which describes, the four ownership sectors of treatment units in regard to to 14 treatment system characteristics. The entries in the cells of the table refer to the size of the percentage rate of association between given sectors, compared to the other sectors, and system charactersitics. The criteria for small, large or no substantive percentage rate of association are ±5 percentage points from the mean value. The rows of the table compare the ownership sectors in regard to each system characteristic and the columns describe the ownership profiles. As shown in the table, there were relatively large associations between each of the following delivery system characteristics and forprofit ownership: the provision of medical model detoxification, care in hospital settings, the operation of employee assistance and occupational alcoholism programs, and service to principal populations residing in suburban areas (the highest economic level grouping in this study). The provision of outpatient care, care in CMHC's, the operation public inebriate programs, and service to principal populations residing in rural areas (second lowest economic level grouping) had relatively small associations with for-profit ownership. The provision of care in CMHC's and freestanding facilities and service to inner city principal populations (lowest economic status grouping) had high associations with nonprofit ownership. On the other hand, the provision of medical model detoxification, care in hospital settings and the operation of employee assistance programs had low associations with nonprofit ownership. There were large associations between provision of outpatient care, care in CMHC's, the operation public inebriate programs and service to rural principal populations (second lowest economic grouping) and State/local ownership. State/local ownership had small associations with the provision of medical detoxification, inpatient care, care in hospital settings, care in freestanding settings and the operation of employee assistance and occupational alcoholism programs. In addition, there were small associations between State/local ownership and service to other urban (second highest economic grouping) and suburban (highest economic grouping) populations. There were large associations between Federal ownership and the provision of inpatient care, outpatient care, care in hospital settings, the operation of employee assistance programs and service to other urban populations (second highest economic grouping). Federal ownership had small associations with the provision of care in CMCH's and freestanding settings and service to suburban populations (highest economic grouping).

There is much concern voiced in the alcoholism field that economically more disadvantaged clients are increasingly being underserved. Some attribute this situation to a growing separation between treatment delivery in the private and public sectors (Weisner and Room, 1984) others attribute it to a separation between the private-for-profit and nonprofit sectors, (Miller and Hester, 1986). An impression is conveyed, largely unsupported by systematic, empirical studies, that the private sector generally, or the private-for-profit sector specifically, characteristically serves economically more advantaged clients and provides relatively expensive medical model, inpatient, and hospital-based services. In order to test this contention, a hypothetical profile of treatment unit delivery systems was constructed, based on the characteristics included in this study. This profile conforms to the aforementioned characteristics which have been attributed to the private or the private for-profit, sector. Comparisons between the hypothetical profile and each of the ownership profiles are presented at Table 9. The entries in column 1 of the table refer to the hypothesized rates of association between unit membership in the hypothesized group and delivery system characteristics. For example, a relatively large percentage of units within this group would provide medical model detoxification and care in inpatient settings, whereas, relatively small percentages would provide social-setting detoxification and care in outpatient settings.

A difference between the hypothesized profile and any given ownership profile was defined as any difference between an entry in column 1 of Table 9 and an entry for the given ownership profile in Table 8 in regard to the same system characteristic. A difference between an entry of "large" and an entry of "small" was regarded as a full difference and given a score of 1.0. A difference between an entry of no substantive association and entries of either large or small were scored 0.5. No difference between the hypothesized profile and any given ownership profile in regard to the same characteristic was scored 0.0. Since, each profile is based on 14 treatment system characteristics, there are 14 possible comparisons between each ownership profile and the hypothesized profile.

As indicated in the Table, the ownership profiles in order of decreasing similarity to the hypothesized profile, in terms of ~~the percentage~~ of the ratio of their total profile difference scores to the maximum possible difference score ~~their comparisons involving differences~~ were, for-profit, 17.~~8~~9%, federal, 35.7%, nonprofit, ~~71.4%,~~ 750 and State/local, 85.7%.

Discussion

The study investigated the question of the existence, on the national level, of separate public and private sector alcoholism treatment delivery systems in regard to the economic status of clients served, treatment settings and types of care provided. Public and private sector profiles, based on 14 subcategories of the aforementioned delivery system characteristics, were constructed and compared. Each of the profiles was also compared to an hypothesized profile, based on perceptions drawn from the literature of the characteristics of treatment delivery in the private sector, generally or the private for-profit sector, specifically, i.e. service to clients at higher economic status levels and the provision of relatively expensive medical model, inpatient and hospital-based services. The results of the analysis support the conclusion that two separate systems of treatment delivery existed, nationally, during the study period. One of the systems, which closely resembled the hypothesized profile, characterized treatment delivery in the for-profit sector and, to a lessor degree, the Federal sector. The other system closely resembled the inverse of the hypothesized profile, i.e. service to clients at lower economic levels and the provision of relatively inexpensive social-setting detoxification, outpatient care and treatment in non-hospital settings. This system characterized treatment delivery in the State/local sector and, to a lessor degree, the nonprofit sector.

Treatment unit ownership trends between the survey years, i.e. 1979, 1980, 1982 and 1984 were investigated. The for-profit sector was the only one which experienced a percentage increase in number of treatment units between each of the successive years and its percentage increases were substantially greater than any of the other sectors between these years. The changes in the percentages of the total number of units constituted by each ownership sector between successive survey years were also investigated. Overall, the changes were relatively small. The for-profit sector was the only one which increased between each of the years. The State/local sector decreased in its percent of the total number of units between each of the years and the Federal units remained relatively stable. The nonprofit sector, after having increased between 1979 and 1980, decreased in its share of the total through 1984.

If the following assumptions are made, the findings of this study have a number of implications for the delivery of alcoholism treatment nationally: (a) The relationships between treatment delivery system characteristics and sector ownership which were found to exist as of September 1982 will continue; and (b) The differential patterns of treatment unit ownership sector growth and decline which were found to exist during the period from 1980 to 1984 will continue.

The major implications of the study follow:

(1) The proportion of the nation's treatment units that provide medical model detoxification or inpatient care or treatment in hospital settings will continue to increase, whereas the proportions providing social setting detoxification, or outpatient care or treatment in non-hospital settings will continue to decline.

(2) The proportion of the nation's treatment units that serve clients at lower economic status levels will continue to decline, as evidenced by the following trends: (a) decreasing proportions of units which serve inner city and rural populations; (b) increasing proportions

of units which serve urban and suburban populations; (c) decreasing proportions of units which provide public inebriate programs; and (d) increasing proportions of units providing Employee Assistance and and Occupational Alcoholism Programs which serve employed clients.

The aforementioned national trends are of particular importance in the light of mounting research evidence that, for most clients, social-setting detoxification, outpatient care and nonhospital-based care are at least as effective but substantially less costly than medical model detoxification, inpatient care and hospital-based care respectively. These trends merit further monitoring. In addition, research which investigates the cost, productivity and effectiveness of treatment delivery as a function of public and private sector treatment unit ownership is called for.

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[1] For more detailed information regarding the definitons used in this study, see U.S. Department of Health and Human Services. National Drug and Alcoholism Treatment Utilization Survey; Comprehensive report, Rockville, Maryland, 1983, Appendix C.

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[2] The justification for this usage is based, in part, on United States census data for 1982 (Department of Commerce, 1985). The population residence categories used in the census are: 1) central cities within metropolitan areas, 2. outside of central cities but within metropolitan areas, and 3. outside of metropolitan areas. According to the Census Bureau definition, category 1 is similar to the combined categories of inner city and other urban used in this study. Categories 2 and 3 are also similar to the suburban and rural categories respectively, used in this study (Appendix 3, pp 873-874). In 1982, the median income for the White population in residence category 1 above, was $23,906 compared to the median incomes of the White populations in residence categories 2 and 3 which were $28,329 and $20,867 respectively. A similar pattern held for the Black populations.

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[3] It should be noted that the +5% criterion is a subjective judgement. The reader may construct profiles by the aformentioned method, using other criterion values.

Table 1. Subcategory distribution of treatment units within each ownership sector, in percent, for 1982.

Ownership	%
For-Profit (N=295)	
Individual	12.5
Partnership	10.5
Corportation	76.9
Non profit (N=2769)	
Church related	6.4
Corporation	86.5
Other	7.2
State/local (N=964)	
State	36.5
County	41.6
City	8.2
City-County	2.9
Hospital District	1.7
Other Substate	9.1
Federal (N=204)	
Public Health Service	12.3
Armed Forces	19.6
Veteran's Admin.	49.0
Federal Prison Systems	5.9
Other	13.2

TABLE 2. Type of care provided by treatment units in each ownership sector, in percent

Type of care[a]	For-Profit (N=295)	Nonprofit (N=2769)	State/local (N=964)	Federal (N=205)
Medical model detox	35.2	12.2	15.3	24.4
Social setting detox	5.4	9.6	7.0	2.9
Inpatient care[b]	44.1	38.1	22.3	61.5
Outpatient care	48.8	59.7	74.7	73.2

[a] Categories are not mutually exclusive

TABLE 3. Specialized programs provided by treatment units in each ownership sector, in percent

Specialized program	For-Profit (N=295)	Nonprofit (N=2769)	State/local (N=964)	Federal (N=205)
Public Inebriate	3.0	13.3	15.3	5.4
Employee Assistance	43.0	26.2	28.9	50.2
Occupational Alcoholism	21.7	12.2	11.1	21.5

TABLE 4. Residence of the principal population served by treatment units in each ownership sector, in percent

Residence (Economic Status)[a]	For-Profit (N=295)	Nonprofit (N=2769)	State/local (N=964)	Federal (N=205)
Inner City(I)[b]	10.1	20.4	12.7	16.5
Other urban (III)	41.3	35.1	31.1	45.3
Suburban (IV)	40.6	17.1	14.4	14.1
Rural(II)	7.8	26.0	41.7	23.9

[a] Residence is used as a surrogate measure of the economic status of the principal population. (See footnote 2 for the justification).

[b] Roman numerals refer to rankings re economic status from lowest (I) to highest (IV).

TABLE 5. Settings of treatment units in each ownership sector, in percent

Organizational environment	For-Profit (N=295)	Nonprofit (N=2769)	State/local (N=964)	Federal (N=205)
Community Mental Health Center	2.7	20.1	33.1	3.4
Hospital	41.4	12.4	19.3	51.7
Correctional facility	0.0	0.4	4.6	6.3
Freestanding facility	37.6 (54.1)[b]	53.2 (65.7)	25.8 (41.3)	24.4 (37.3)
Other[a]	18.3	13.9	17.2	14.2

[a] Verfication of a 10% sample of units that selected this category indicated that 90% of them were located in freestanding facilities.

[b] Numbers in parentheses are the percentages based on the assumption that 90% of the "other" category in each of the ownership sectors are freestanding facilities.

TABLE 6. Percent change in number of treatment units in each ownership sector between survey years.

Ownership	1979 to 1980	1980 to 1982	1982 to 1984
For-profit	24.6	19.0	188.5
Nonprofit	8.2	-6.4	56.2
State/local	-.7	-9.2	51.3
Federal	-8.4	4.6	35.1

TABLE 7. Percent of all treatment units in each ownership sector by survey year

Ownership	1979 (N=4219)	1980 (N=4465)	1982 (N=4233)	1984 (N=6912)
For-profit	4.7	5.6	7.0	12.3
Nonprofit	64.8	66.3	65.4	62.6
State/local	25.4	23.9	22.8	21.1
Federal	5.1	4.4	4.8	4.0

TABLE 8. Ownership sector profiles: percentage rates of association between ownership sectors and treatment system characteristics.

Characteristic	For Profit (N=295)	Nonprofit (N=2769)	State/local (N=964)	Federal (N=205)	Mean[a] (%)	SD[b] (%)
Medical detox	large[c]	small[d]	small	-----[e]	21.8	9.0
Social detox	------	------	-----	-----	26.2	2.4
Inpatient	------	------	small	large	41.5	14.0
Outpatient	small	------	large	large	64.1	10.6
Hospital	large	small	small	large	31.2	16.0
CMHC	small	large	large	small	14.8	12.6
Freestanding	-----	large	small	small	49.6	11.6
Inner City I	-----	large	-----	-----	14.9	3.9
Rural II	small	------	large	-----	27.4	12.0
Other Urban III	-----	------	small	large	38.2	5.5
Suburban IV	large	------	small	small	21.6	11.1
P.I. Program	small	------	large	-----	9.2	5.2
Employ Assist.	large	small	small	large	37.1	9.9
Occup. Alc.	large	------	small	-----	16.6	5.0

[a] The mean of the percentage rates of association between the ownership categories and the treatment system characteristics.

[b] Standard deviations of the percentage rates of association.

[c] A substantively large percentage rate of association compared to the other ownership categories, i.e. at least 5 percentage points greater than the mean value.

[d] A substantively small percentage rate of association, i.e. at least 5 percentage points smaller than the mean value.

[e] No substantive association.

TABLE 9. Hypothesized[a]-ownership sector profile differences[b]

haracteristic	Hypothesized (N^c=14)	For-profit (N=295) (N^c=14)	Nonprofit (N=2769) (N^c=14)	State/local (N=964) (N^c=14)	Federal (N=205) (N^c=14)
edical detox	large	(0.0)	(1.0)	(1.0)	(0.5)
ocial detox	small	(0.5)	(0.5)	(0.5)	(0.5)
npatient	large	(0.5)	(0.5)	(1.0)	(0.0)
utpatient	small	(0.0)	(0.5)	(1.0)	(1.0)
ospital	large	(0.0)	(1.0)	(1.0)	(0.0)
MHC	small	(0.0)	(1.0)	(1.0)	(0.0)
eestanding	small	(0.5)	(1.0)	(0.0)	(0.0)
ner City (I)	small	(0.5)	(1.0)	(0.5)	(0.5)
ral (II)	small	(0.0)	(0.5)	(1.0)	(0.5)
her urban (III)	large	(0.5)	(0.5)	(1.0)	(0.0)
burban (IV)	large	(0.0)	(0.5)	(1.0)	(1.0)
program	small	(0.0)	(0.5)	(1.0)	(0.5)
ploy Assist.	large	(0.0)	(1.0)	(1.0)	(0.0)
cup. Alc.	large	(0.0)	(0.5)	(1.0)	(0.5)
tal		(2.5)	(10.5)	(12.0)	(5.0)
		17.6% [illegible]	71.4% [illegible]	85.7%	35.7%

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ALCOHOL, INJURY, AND LEGAL CONTROLS:
SOME COMPLEX INTERACTIONS

Law, Medicine and Health Care

(In Press)

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Despite considerable declines in the early 1980's, drunk driving remains a major public health problem in the U.S. In 1986, 46,050 people were killed on the nation's highways. Traffic crashes are the leading cause of death in the age group 1-34 years (Ross 1982). Alcohol is unquestionably a major contributor to these crashes. In 1986, 23,987 traffic deaths, 52% of the total, involved a driver or pedestrian who had been drinking, and 16,728, 36% of the total, involved someone with a blood alcohol level above .10% (Fell 1987) (U.S.DOT 1988). Many of the victims of drunk driving crashes were not drinking at the time of the event; more than one third of alcohol related vehicular deaths were persons other than drinking drivers: passengers, other drivers or pedestrians.

Legal Controls For Drunk Driving:

Legislation may influence drinking and driving behavior, and the consequences thereof, in a variety of ways: limiting access to alcohol; restricting access to vehicles; making vehicles and roadways safer; separating drinking and driving. Taxation, dram shop laws, minimum drinking ages, server liability, land use laws pertaining to the location of alcohol outlets, and prohibitions on advertising alcoholic beverages affect the driver's access to alcohol. Licensing and curfew laws restrict access to vehicles among adolescents and teenagers. Laws which regulate speed, use of seat belts, vehicular safety features or roadway design prevent or ameliorate some alcohol-related crashes. Criminal and administrative per se laws, mandatory sentencing, administrative license suspension, and point of sale warning laws are aimed separating drinking from driving.

The evidence that drinking is associated with increased risk for vehicular injury and death is substantial. Laboratory and field studies demonstrate that alcohol impairs sensory and motor skills required for safe driving (Perinne 1973). On the basis of case control studies, comparing alcohol exposure among persons in traffic crashes to comparable persons not in traffic crashes, the National Academy of Sciences concluded that if no one drove after drinking, U.S. traffic deaths would decline by 24% (Reed 1981).

Evaluating Drunk Driving Interventions:

Knowledge of the effectiveness of legal countermeasures to drunk driving is less conclusive. Evaluation of drunk driving laws is constrained by several factors. First, most states do not obtain blood alcohol information on all drivers involved in fatal crashes. Accordingly, researchers cannot assess whether crashes involving intoxicated drivers decline as a proportion of all crashes following a new law. Because the key dependent variable cannot be precisely observed, researchers have used surrogate measures such as single vehicle nighttime fatal crashes. Based on estimates from states that comprehensively test alcohol levels of driver in fatal crashes, sixty to seventy percent of single vehicle nighttime fatal crashes involve intoxicated drivers. But, less than half of fatal crashes involving intoxicated drivers are single vehicle nighttime crashes. Thus, some researchers have cautioned that such surrogate measures are so imprecise that their use can, on occasion, lead to incorrect conclusions (particularly short term studies of small juristictions) (Heeren et al 1985).

Second, persons who drive after heavy drinking are are disproportionately young males and are less likely to wear seat belts, more likely to drive after using psychoactive drugs, and more likely to have been arrested for speeding, running red lights, and other moving violations (Hingson, Howland 1987). (Table 1).Consequently, fatal crash reductions may be less than reductions in drunk driving behavior because persons who reduce drinking and driving remain at high risk for vehicular injury.

Third, drunk driving laws usually do not occur in isolation. When several related laws are enacted within a short period of time it is difficult to attribute effects to a specific intervention. Also, numerous confounding variables can influence alcohol related vehicular crash rates. Yet variables such as unemployment rates, use of seat belts, and rates of speeding are seldom, if ever, controlled analytically in research evaluating drunk driving interventions.

Previous research on the impact of drunk driving laws clearly shows that the effects of similar laws can vary widely from state to state. This limits ability to generalize research findings from one region to another.

Effectivness Of Legal Controls:

Limiting Access to Alcohol

Nevertheless, well executed studies indicate that laws can affect drinking and driving behaviors. Increasing taxes on alcohol has been shown to be associated with reduced drinking, specifically among teenagers (Grossman, Coate, Arluke 1984, Saffer, Grossman 1985, Coates and Grossman 1986, Moskowitz 1986), and declines in fatal crashes (Cook).

The preponderance of evidence (Cook and Tauchen 1984, Williams et al, Klein 1983, Wagenaar 1983, Hingson 1983 et al, National Highway Traffic Safety Administration 1985) also indicates that although effects vary widely from state to state, increasing the legal drinking age generally reduces teenage nighttime fatal crash involvement in the targeted age groups by about 13% and overall fatal crash rates in the targeted age groups by about 9% (DuMouchel, Williams and Zador 1985). Unfortunately, despite increases in the legal drinking age, teenage crashes remain disproportionately high. Though teenage drivers represent only 7% of licensed drivers in the United States, they were involved in 17% of the fatal crashes and accounted for 18% of traffic fatalities in 1986 (U.S. DOT 1986).

Restrictive Access to Vehicles

Minimum driving age laws also reduce traffic fatalities (particularly those most likely to involve alcohol) among affected age groups (Williams, Karpf and Zador 1983, Williams and Lund 1985) without any apparent increase in the rate of fatalities once teenagers obtain licenses. Teenagers are overrepresented among nighttime traffic fatalities and night fatal crashes disproportionately involve alcohol. In recent years, 12 states have adopted nighttime driving curfews. One study concluded that curfews result in substantial reductions in crash involvement among 16 year olds (Preusser et al 1984).

Making Roadways Safer

A thorough study by the National Research Council concluded that the 1974 55 mph speed limit accounted for 3,000 to 5,000 fewer highway deaths during the first year following enactment. Adjusting for reductions in fatality rates during the last decade as well as for the increase in travel and average speeds, the Council estimated that in 1983 the 55 mph law still saved between 2,000 and 4,000 lives (National Research Council 1984). In 1987, 38 states raised their speed limits on rural interstate highways. In the first 9 months fatal crashes increased 23% on rural interstates in those states, whereas they declined 13% on urban interstates and 5% on non-interstate roads where limits were not raised (U.S. Department of Transportation 1988).

Because of poorer sensory motor coordination and slower reaction time, drunk drivers are particularly vulnerable to crashes at higher speeds. A 1981 drunk driving law in Maine had initial beneficial effects on fatal crash rates compromised, in part, due to reductions in speeding enforcement and attendant increases in in average driving speeds. A subsequent two-year upturn in fatal crashes was reversed when a speeding enforcement crackdown was initiated (Hingson, et.al. 1987).(Figure 1).

The National Research Council (1984) also estimated that seat belts have the potential of reducing vehicular deaths by 12,000 per annum. In 1984, over 90% of motor vehicle occupants killed in crashes involving drunk drivers were unbelted. Since that time, 33 states comprising over 80% of the U.S. population have adopted mandatory belt use laws. Through 1986 they were estimated to have prevented more than 1,000 deaths nationwide. (Campbell in press). However, persons who drive drunk may be least likely to adopt seat belt use (Hingson 1988, Williams 1988) and the impact of these laws on drunk driving deaths has not been delineated.

Federal laws introduced in the 1960's required a number of automobile safety design standards such as installations of seat belts, energy absorbing steering columns, head restraints and side door beams. There is little literature evaluating the effectivess of these standards, but one study suggests that safer vehicle construction has reduced traffic fatalities by 15 to 35 percent (Graham and Garber 1984). The effectiveness of roadway design in preventing crashes is suggested by the fact that accident rates on interstate highways are considerably lower than on secondary roads (U.S. Department of Transportation 1985). While new safety standards such as those requiring automatic restraints in new automobiles have the potential to reduce injury and death in drunk driving crashes, typically persons who report driving after heavy drinking drive older vehicles (in a recent New England survey, 75% drove vehicles over 5 years old). That suggests new safety standards will often take several years to affect high risk drunk drivers.

Separating Drinking from Driving

During the 1980's, states have intensified efforts to reduce drunk driving by adopting legislation, modeled after Scandinavian deterrence laws, aimed specifically at separating drinking from driving. Although these laws differ somewhat from state to state, they may be categorized as: (1) laws that define per as an offense per se driving with blood alcohol concentrations above a specified level (usually .10%); (2) laws that require administrative license suspensions upon arrest regardless of the outcome of prosecution; and, (3) laws that require sentencing (jail or community service) for first offenders. Zador et al (1988) have studied the independent effects of these laws by comparing fatality rates for specific age groups - at specific times per day - among states with deterrence laws to neighboring states without deterrence laws. These authors conclude that if all of the 48 contiguous states adopted deterrence laws another 2,600 fatal driver involvements could be prevented each year. (Zador et al 1988). Per Se laws, particularly administrative per se laws, were associated with the greatest fatal crash declines.

Short Term VS. Long Term Effects:

But, attempts to scientifically assess the effectiveness of drunk driving deterrence laws reveal a common pattern of response. Frequently, new drunk driving legislation results in a decrease in alcohol related traffic fatalities in the period immediate following enactment. Typically, however, this response is short-lived. Within months, or years, drunk driving crash rates resume pre-law levels. Of note, Zador's study covered the 1978 to 1985 time period but in 1986, after several years of decline, single vehicle night fatal crashses rose 7% (Hingson 1988). (Figure 2). Declines and increases were even more marked among teen drivers (Figure 3).

Ross (1982) has reviewed the international experience with similar per se legislation from several countries including great Britain, France, Australia, New Zealand, Holland and Canada. The effects of the 1967 British Road Safety Act are typical. That law made it illegal per se to drive with a blood alcohol level above .08%. Initially the law was followed by a 24% decline in alcohol traffic fatalities. But within two to three years fatal crashes began to return to pre law levels.

In 1981 Maine passed a .10% criminal per se law with administrative provisions and a new civil drunk driving charge that increased the likelihood of conviction and stiffened penalties. In the law's first year, the proportion of Maine drivers that believed drunk drivers stopped by the state's police would be convicted increased, relative to an adjacent state (Massachusetts). The proportion of drivers reporting decisions not to drive after drinking also increased. Single vehicle night fatal crashes declined 33%, more than in any other New England state. However, by the third postlaw year, both the proportion of drivers reporting decisions not to drive after drinking and fatal crashes returned to prelaw levels (Hingson et al 1987).

What explains this apparent evanescence of drunk driving deterrence laws? One interpretationn gaining wide acceptance among traffic safety researchers is that drunk driving laws function only to the extent that they alter the public's perception of the probability of being apprehended and convicted. Once the public learns by experience that new laws have little impact on the probability of apprehension, prelaw drinking and driving behaviors resume.

Survey data collected in New England demonstrate that even through enforcement increased during the 1980's, drunk drivers were arrested only 2-3 times for every 1,000 drunk driving trips (Hingson 1987). (Table 2). This risk is only slightly higher than risk for crash involvement. Thus, one could theoretically drive drunk once each weekend for almost 10 years before being apprehended. Even a doubling or trebling of these odds is apt to leave the drinking driver unimpressed. Because no practical level of enforcement will materially change the likelihood being caught, deterrence laws, however severe, pose a very slight risk in terms of realizing penalties for drunk driving. This has led some researchers and policy makers to conclude that sustained effects for drunk driving laws can only result from maintaining the illusion of a high level of enforcement. Towards this end, strategies which increase the visibility of enforcement have been implemented with increasing frequency. An example is the sobriety check point which stops drivers at random. The constitutionality of this approach has been debated and some (but not all) state supreme courts have disallowed the practice (Jacobs and Stossen 1985).

But even if highly visible enforcement programs proved temporarily effective, one wonders whether long term reductions in drunk driving would result. It seems likely that any intervention which is based upon the illusion of enforcement must ultimately produce effects of limited duration. This raises the question of what strategies of enforcement must follow sobriety check points if their effects begin to wane and the extent to which the public will tolerate the intrusion and inconvenience of highly visible enforcement procedures.

What then is the future of legal interventions for reducing drunk driving? Some are pessimistic regarding the long term effectiveness of law in reducing drunk driving and related fatalities. Others contend that as long as the probability of apprehension and convictions remain very low, the distribution of punishment remains essentially random and therefore unjust (Ross 1982). Nevertheless, we argue that legal sanctions have a vital role to play in reducing alcohol related vehicular crashes. Our thesis is that laws function beyond the direct deterrence effect evoked by fear of apprehension; that laws both reflect and promote social change regarding drunk driving; and, that ultimately, drunk driving laws may function less by direct deterrence and more by their effects on public attitudes and norms.

Laws And Behavior:

Most behavior is not regulated or determined by law. As Goffman (1959) notes, public behavior tends to follow well defined scenarios. Social norms suffice to ensure that the majority of public acts and interactions occur relatively predictably and without incident. Ross (1982) has argued that the reason drunk driving laws function only by way of engendering fear of apprehension is because drinking and driving is acceptable behavior in our society. He states that drunk driving laws are the quintessential mala prohibita, or acts which in the absence of law violate no other social norm. But if drunk driving laws exist without the scaffolding of moral sanction, from whence do they originate? Undoubtedly some traffic laws are enacted without strong public consensus. The recently rescinded Massachusetts seat belt law provides an example (Hingson et al 1988). Prior to and even following that law most residents of Massachusetts did not wear belts. But the drunk driving laws of the late 1970's and early 1980's seem to suggest the development of new social mores about the appropriateness of drunk driving. Even prior to the passage of those laws, most persons did not drive drunk. It is easier to focus public disapproval on a minority behavior than more commonplace behaviors such as non-belt use or speeding. Also, a stronger case can be made for drunk drivers posing a danger to others than non-belt users. Pressure to pass drunk driving laws was stimulated primarily by grassroots citizens groups like MADD and RID, whereas, the Federal Government played a larger role in promoting seat belt laws and the 55mph speed limit.

The Movement Against Drunk Driving:

The enactments of the drunk driver laws during the last decade were not isolated events. Rather they were part of a larger movement which reflected the perception of drunk driving as a social problem amenable to change.

Evidence of the breadth of the movement against drunk driving is provided by measures of social activism, legislation, media attention and reported behavioral changes in the population. Mothers against drunk driving (MADD) and Remove Intoxicated Drivers (RID), two important anti-drunk driving activist groups first formed in 1978 and 1980, respectively. By 1985, 424 local chapters of these groups had organized at the community level (McCarthy, Wolfson and Harvey, 1987). (Figure 4). The growth of these organizations is notable for two reasons. First, MADD and RID have played important roles in raising public consciousness about drinking and driving. Second, their expansion is a reflection of the public's receptivity to hearing about and taking action about the problem.

In the five years between 1981 and 1986, states passed 729 laws pertaining to drunk driving (Hatos 1987). During this period, the number of these laws enacted increased by 300%, from 44 in 1985 to 178 in 1986. In 1985 alone, 223 drunk driving laws were passed and as of August 1987, 1165 new measures where proposed in 49 states.

The dissemination of anti-drunk driving social activism and legislation is mirrored by media attention. The number of magazine and newspaper stories, as measured by analysis of leading periodicals, increased dramatically during the early 1980's. In the U.S., the number of major national newspaper and magazine stories about drunken driving increased 50 fold from 1980 to 1983, but decreased thereafter. (McCarthy, Wolfson and Harvey, 1987).(Figure 5).

Random digit dial surveys conducted by the Center for Disease Control (CDC) of adult populations in 15 states show that between 1984 and 1986 the percent of respondents who report "driving after drinking too much in the last month" decreased in 73% (11/15) of these states (CDC 1986, CDC 1987).

Attitudes Towards Drunk Driving:

It has been argued that the present trends towards decreased drinking and driving after drinking represent a cyclic correction to the 1960's when use of alcohol and drugs increased substantially. Attitudes towards drinking and driving, however, may also be viewed in the larger context of health related behavior change occurring throughout the 1970's and 1980's. Smoking, consumption of high cholesterol foods and the current craze for exercise all reflect the development of norms and behaviors associated with risk reduction. Indeed, Goldman and Cook (1984) estimate that over half of the decline in heart disease mortality between 1968 and 1976 was attributable to alterations in lifestyle. Musto suggests that drinking habits are changing due to the perception of alcohol as a substance dangerous to health (Higgins 1988). A 1986 national Gallup Poll indicated that 75% of the adult population thought that federal law should require TV and radio stations carrying beer and wine commercials to provide equal time for health and safety warning messages about drinking; 79% thought that federal law should require health and safety warning labels on alcoholic beverages containers (Gallup 1986).

Laws And Social Norms:

The drunk driving laws of the last decade did not occur deus ex machina; nor, we contend, do they exert their effects only through fear of apprehension. Laws are an expression of emerging social norms. In this sense, they are statements by society of new standards of acceptable behavior. An evaluation we recently completed in Massachusetts showed that reports of driving after drinking, and after heavy drinking, as well as nighttime and single vehicle nighttime fatal crashes, actually declined more before enactment of the 1982 Massachusetts deterrence laws than after that law (Hingson, et al 1983). Similarly, in Maine, where a series of deterrence laws was passed in 1981, single-vehicle nighttime crashes declined 22% the year prior to enactment of the laws (Hingson et al 1987). This temporal sequence suggests that the same attitudinal changes which gave rise to the laws also affected drinking and driving behaviors.

Andeneas (1978) has proposed that legal sanctions function in several modes to alter behavior. The deterrent effect -- the effect we expect and measure -- is one mode. But, laws also function to communicate social expectations and habituate new behaviors. New laws may help to define for the individual new standards of appropriateness. Thus, deterrence may be only one step in a process by which behavior becomes internalized. In responding to changes in social norms, as opposed to only fear of apprehension, the individual can become the monitor of his own behavior and through his actions and attitudes the disseminator of behavioral change. Peers can also monitor each other's behavior and exert influence by confirming new norms.

We suggest that drinking and driving laws be viewed within the context of the development of social norms about the appropriateness of drinking and driving. The model we propose begins with the perception of drunk driving as a social problem and progresses to social activism and the formation of the political consensus required to enact legislation. Public debate about the law raises salience of the issue in public consciousness. Also, the legislation has the immediate effect of deterring drunk driving by reason of fear of apprehension. Those effects can, however, dissipate in the short run, particularly if media attention to the law and enforcement slackens. But effects of the law in anchoring new social attitudes may continue. Initially, only those most law abiding — and least apt to drive drunk -- conform. In doing so, however, they develop new behaviors which serve as the foundation for drinking and driving social scenarios: the host assumes responsibility for insuring that guests do not drive home drunk; groups designate drivers who refrain from drinking; drinking mineral water with a twist instead of alcohol is viewed with approbation. Gradually, these behaviors are adopted by increasingly larger segments of society. New norms emerge.

Throughout this process, the law functions as both deterrent and as a statement and reinforcer of social expectations. For example, in Massachusetts we evaluated the effects of the 1982 drunk driving legislation using several outcome measures in addition to traditional alcohol related vehicular crashes. Before and after the legislation we surveyed a sample of adults regarding attitudes towards drunk driving. Between 1982 and 1983 the proportion of drivers who said they would not care if their best friend learned they had been arrested for driving drunk declined from 25% to 12%.

This sequence of events is not, of course, predestined. Public concern about drunk driving may wane before social norms become firmly established. We have seen, for example, a gradual erosion in compliance with the 55 mph speed laws and, in 1987, 38 states passed legislation raising speed limits on some of their roads. Our point is not that new norms about drinking and driving are inevitable but that the process of perceiving a social problem and enacting and enforcing legislation to address the problem must be viewed within the context of public attitudes and beliefs. Understanding the role of the law in shaping social norms and understanding the role of social norms in modifying individual behavior may inform the way in which we think about and implement legal countermeasures.

Implementing Legal Controls:

Viewing the law as an element in the process of social change has implications for how we implement and evaluate drunk driving legislation. To the extent that laws function to disseminate and reinforce social norms about drunk driving, outcome measures of the impact of laws should include attitudes about the laws and their enforcement as well as behavioral variables. The periods of pre and postlaw observations should be extended to allow time for normative change to occur and to observe when it occurred relative to the passage of the law. This would permit assessment of whether or not the law initiates, or reinforces, normative change..

If laws contribute to social change by way of the evolution of behavioral norms then the implementation of these laws should be accompanied by activities which are aimed at accelerating social change. In other words, simply increasing enforcement, or the illusion of enforcement, may be of limited value; legal interventions should be enacted along with educational programs intended to heighten informal social pressure not to drive drunk and to disseminate behavioral alternatives to drinking and driving.

Those interested in traffic safety could learn from experiments in changing cardiovascular risk factors. The effectiveness of community-wide, multi-strategy, interventions for changing heart disease risk factor behaviors (eg. smoking, diet, alcohol consumption, and sedentary lifestyle) has been demonstrated by several large scale controlled studies: North Karelia, Finland (Puska et al, 1983), California (Farquhar 1978) and Minnesota (Jacobs et al 1985). These programs did not target only high risk groups but rather directed interventions at the total society through interventions conducted via the media, schools, workplaces and community organizations. Significant positive behavior changes were reported across socio-economic and risk factor strata among the intervention populations. Although these studies did not involve legal interventions, they show the potential impact of developing, and accelerating, a process of consensus about the value of altering risk behaviors.

Similar, multi-strategy community-based intervention programs should be developed around traffic safety. The success of the community cardiovascular programs in reducing risk factors for heart disease reflects the simultaneous impact of these programs on the individual and the individual's social milieu. Moreover, these programs are aimed at changing a number of interrelated behaviors. Community-based traffic safety initiatives which focus on accelerating the development of social norms about driving behaviors among all residents and which targeted not only drunk driving but also speeding and seat belt use might generate synergistic effects comparable to the community-based heart disease interventions.

Recent Trends In Alcohol Related Crashes:

Public concern about the dangers of alcohol consumption vary in intensity over time. Whether the late 1970's and 1980's emerge as an era of significant and permanent change in social norms about drinking and driving remains to be seen. It is apparent, however, that we are currently witnessing at least the nascent stages of change in this direction. A Harris poll of a national sample of adults conducted annually since 1983 reported that the percent of drivers who say they "never drink after driving" or "never drink at all" increased significantly from 68% in 1984 to 74% in 1986 (Taylor and Kagay 1987). A 1986 roadside breath survey supports these findings: the proportion of breath tested drivers with high levels of blood alcohol had decreased by more than a third relative to a comparable 1973 survey (Zador et al 1988).

The rate of alcohol related vehicular fatalities remained fairly constant at 11.5 deaths per 100,000 population from 1977-1981; but, in 1982 the rate began to decline (Casement 1987). Between 1982 and 1985, the number of drivers involved in fatal crashes increased by 3%, from 56,029 (1982) to 57,844 (1985) (U.S. D.O.T. 1987). But alcohol use by drivers involved in fatal crashes decreased steadily. The proportion of these drivers who were legally intoxicated fell from an estimated 30% in 1982 to 25% in

1985 (U.S. D.O.T. 1987). The proportion of drivers involved in fatal crashes whose blood alcohol was estimated to be between .01-.09% (below the legal level for intoxication) remained relatively unchanged at around 9% (U.S.D.O.T. 1987). There was little change overall in the percent intoxicated among non-occupant (pedestrians and bicyclists) adults involved in fatal crashes indicating that the decline in alcohol related traffic fatalities was due primarily to changes in drunk driver deaths (U.S.D.O.T. 1987). It has been suggested that the decline in alcohol related vehicular fatalities during the early 1980's was associated with economic conditions in the country. Indeed, the decrease in fatalities began when unemployment peaked during 1982 and 1983. However, the decline in fatalities continued through 1985 despite the subsequent economic recovery and record high employment levels.

But these sanguine trends reversed in 1986 and drunk driving fatalities increased - particularly among young drivers. Whether this increase will continue is not clear. Nevertheless, it is interesting that drunk driving fatalities began to rise following decreases in media attention to the problem. (Figures 2,3,5). This suggests that new drivers experienced less exposure to public concern about drunk driving than the cohort preceding them and underscores the importance of persistence in directing resources towards maintaining the development of social norms about drinking and driving.

Attributing major changes in drunk driving and fatal crash trends specifically to drunk driving legal interventions is fraught with methodological problems. Moreover, a causal model which starts with a law and observes only short term outcomes in traffic fatalities seems to ignore the underlying social processes of which the law is simply one expression. We need to understand more about these underlying processes so that we can evaluate the function and empirical impact of the law within their context. With this understanding, we can, perhaps, direct implementation resources towards those activities which reinforce and accelerate the social norms which ultimately mediate behaviors.

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Table 1
Survey of Adult Drivers
in Massachusetts 1985, 1986

Characteristics of Persons Who Drive
After Heavy Drinking (5+ Drinks)

	Times Drove in Past Month After Heavy Drinking		
	0 N=1758	1-3 N=88	4+ N=30
Past Month			
Drove After Marijuana use	4%	18%	41%
Other Drugs	3	4	27
Wore Seat Belts 90% of the times	43	22	11
Past Week			
Ran a Red Light	8	12	18
Speed 20 MPH Over Limit	15	39	32
Past Year			
Driving Violation Other than Drunk Driving	11	29	40
Driver in Crash	9	19	19
Driver in Crash Resulting in Injury	1	2	5
Strongly Oppose			
Seat Belt Law	18	26	26
Safe Roads Act (Drunk Driving Law)	9	17	70
55 MPH Speed Limit	11	12	35

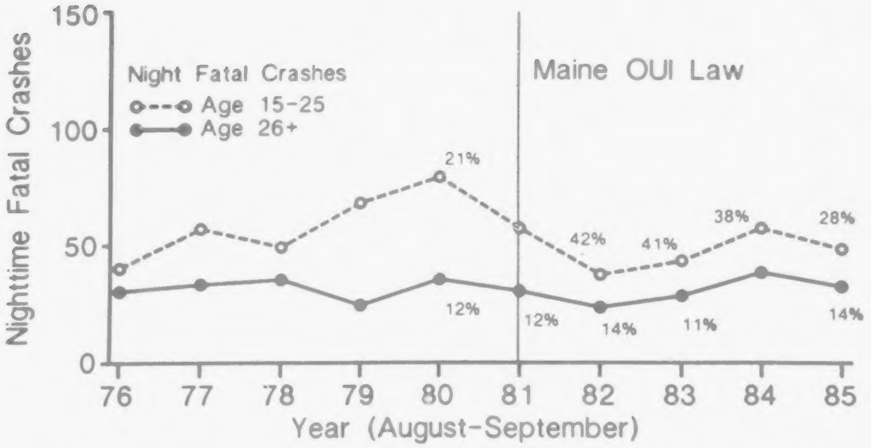
Table 2
Drunk Driving Enforcement
in New England
1982-1985

	1982 N=3,314	1983 N=3,340	1984 N=3,248	1985 N=3,282
Stops After Drinking/ 1,000 D.D. Trips	11.1	16.1	21.1	33.1
Took Breath Test/ 1,000 D.D. Trips	2.5	4.6	3.4	5.9
Tickets for DWI/ 1,000 D.D. Trips	1.0	2.0	2.0	2.8
Accidents After Drinking/ 1,000 D.D. Trips	2.1	2.5	3.0	2.1

D.D. Trip = Trip after 5+ Drinks

Figure 1

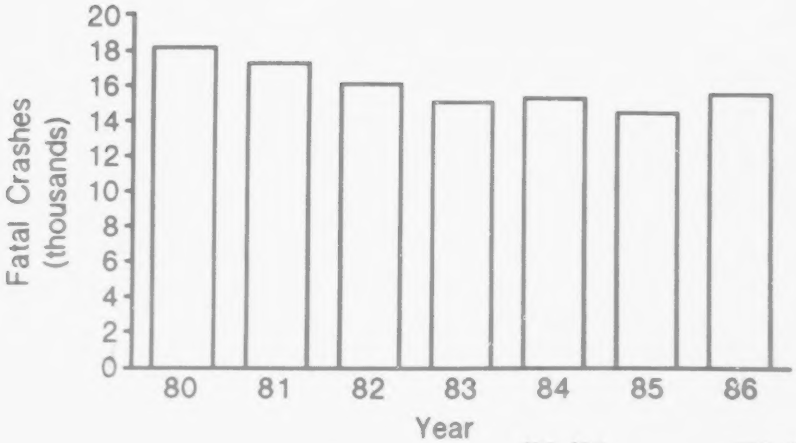
Nighttime Fatal Crashes - Maine
by Age of Youngest Driver



% refer to respondents who decided not to drive because of drinking.

Figure 2

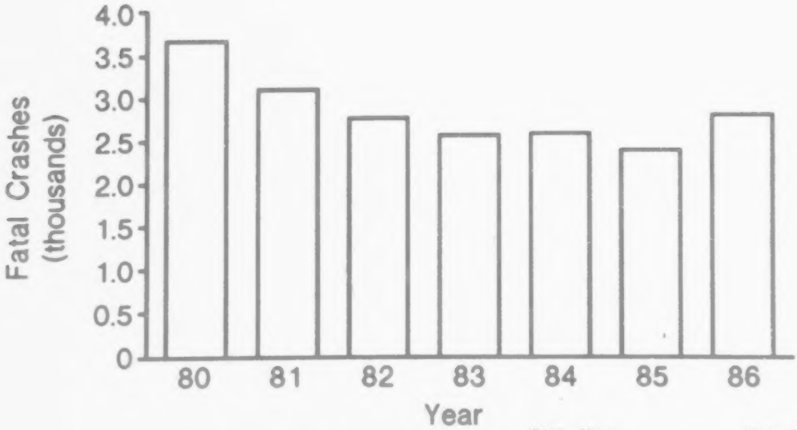
SVN Fatal Crashes Nationwide, All Ages
1980 - 1986



	'80-'85		'85-'86	
SVN Crashes	3,674	↓ 20%	1,894	↑ 7%
Other Crashes	2,442	↓ 9%	834	↑ 3%

Figure 3

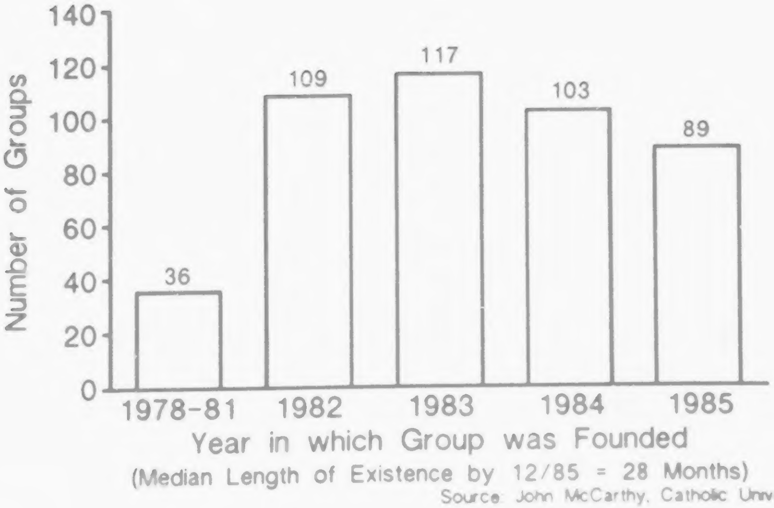
Teen SVN Fatal Crashes Nationwide
1980-1986



	'80-'85		'85-'86	
SVN Crashes	2,497	↓ 34%	702	↑ 17%
Other Crashes	1,212	↓ 20%	290	↑ 6%

Figure 4

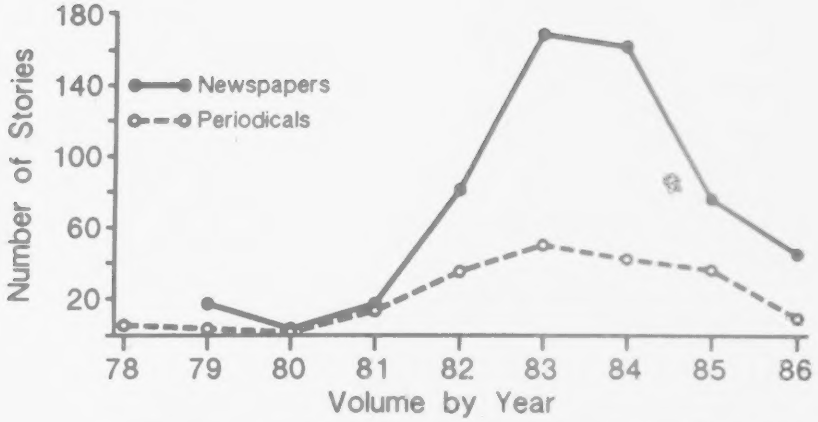
Number of Anti-Drunk Driving Groups
Founded, by Year



Source: John McCarthy, Catholic University

Figure 5

Volume of National Newspaper and
Periodical Coverage of Drunk Driving
by Year



Newspaper Volume based on count of stories in the National Newspaper Index. Includes: N.Y. Times; L.A. Times, Wall St. Journal, Washington Post

Periodical Volume based on Magazine Index

Source: John McCarthy, Catholic University

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Is Treatment for Substance Abuse Effective?

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• Few studies have assessed adequately the effectiveness of alcohol and drug abuse treatments using an appropriate range of reliable outcome measures, a representative sample of alcohol and drug abuse treatment modalities, or more than one perspective on treatment effectiveness. This article evaluates substance abuse treatment using a sample of 742 patients treated in six programs and evaluated at six-month follow-up. The following three major questions were addressed: (1) do patients improve following treatment; (2) are improvements confined to alcohol or drug use, or are they more pervasive; and (3) are these improvements a result of treatment? The results indicated significant and pervasive improvements in virtually all areas for both alcoholics and drug addicts. Major changes were seen in alcohol and drug use, employment, criminal behavior, and psychological function. Patients undergoing long-term treatment showed greater improvement and better six-month outcomes than those undergoing short-term therapy on 12 of 18 criteria. The data provide evidence for the therapeutic benefit of substance abuse treatments.

(*JAMA* 1982;247:1423-1428)

RECENTLY there have been serious challenges to the effectiveness of alcohol and drug abuse treatments, and the impression has been conveyed that their benefits are insubstantial.[1,2] The important question is: What standard of effectiveness shall we accept when there are several reasonable alternatives offering potentially different estimates of treatment worth? For example, is it adequate to know that patients' alcohol or drug use is reduced significantly after substance abuse treatment? The public, the press, and the funding sources have come to expect that patients will also show increased employment, better physical and mental health, and corresponding decreases in hospital utilization, illegal activity, and dependence on welfare after treatment. How realistic are these expectations?

The data derive from our cooperative evaluation of substance abuse treatment funded by the Veterans Administration, the design of which has been described elsewhere.[3] In this study we were able to apply a comprehensive and uniform method of data collection[4] to a sample of 742 male veterans who were alcohol and drug abuse patients, at the time of admission to treatment and again at the six-month follow-up point. The following three specific evaluation issues were examined: (1) do patients improve after substance abuse treatment; (2) are improvements specific to the target symptoms of alcohol and drug use, or are they more pervasive; and (3) to what extent are improvements due to the effects of treatment?

METHODS

Subjects

All male veterans who were admitted for alcohol or drug abuse treatment at either the Coatesville or Philadelphia VA Medical Centers during 1978 were eligible for the study. There were no significant differences in demographic or background characteristics between patients in the two hospitals, and approximately 90% of all subjects were Philadelphia residents. There were no treatment admission criteria other than eligibility for veterans' benefits. Approximately 80% of drug patients were heroin addicts, averaging six years of daily use. The remaining drug abusers reported regular use of amphetamine, benzodiazepines, or hallucinogens. Alcohol abusers averaged eight years of problem drinking, defined as intoxication three or more times per week.

We evaluated 879 male veterans initially who were admitted to alcohol (N=554) or drug abuse (N=325) rehabilitation programs at the Coatesville or Philadelphia VA Hospitals during 1978, and who remained in rehabilitation treatment for at least five days.[3] Seventeen percent of the alcoholics dropped out of treatment within five days as compared with 13% of the drug addicts. This difference was significant ($P<.06$) although there were no significant differences in dropout among the three individual alcohol or the three individual drug programs. We were able to contact approximately 85% of the remaining patients six months after admission to treatment, so complete data were available for 742 subjects (460 alcoholics and 282 drug addicts).

Treatment Programs

The substance abuse treatment network of the VA in the Philadelphia area consists of four inpatient (two alcohol, one drug, one combined) programs at the Coatesville VA Medical Center, plus outpatient alcohol and drug abuse clinics at the Philadelphia VA Medical Center. Once

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admitted to substance abuse treatment programs at either hospital, patients were assigned to one of the six rehabilitation programs on the basis of their personal requests, the clinical judgment of the admitting staff, administrative considerations (eg, bed census), and simple chance.

Following are brief descriptions of the programs; for more complete information see Gottheil et al:

Alcohol Treatment Unit.—Is a 60-day therapeutic community based on the principles of Alcoholics Anonymous (AA). The staff conducts small-group therapy four times weekly.

Fixed Interval Drinking Decisions.—Is a research program designed to examine and treat alcoholism in the presence of alcohol. The six-week treatment cycle consists of two, one-week alcohol-free periods, and a four-week drinking-decisions phase during which 60 mL of 80-proof alcohol is available, and the patients have the opportunity to decide whether or not to drink. Group and individual therapy are offered daily.

Combined Treatment.—Is a short-term (45-day) program that delivers intensive addiction management therapy to both alcoholics and drug addicts. Treatment is based on principles of AA or Narcotics Anonymous with ancillary individual therapy and educational material.

Drug Abuse Rehabilitation.—Offers personal and social treatment in a 60-day program designed to "habilitate" the patient to society using individual and group psychological therapy, educational and vocational counseling, and the social structure of a self-governing therapeutic community.

Alcohol Outpatient.—Is a variable-length treatment program that concentrates on the medical, psychological, and social problems of the outpatient alcoholics. Therapeutic goals include alcohol abstinence through problems associated with alcoholism.

Methadone Maintenance.—Offers methadone maintenance, in combination with a full program of psychiatric and social-work counseling. Chemotherapeutic and individual psychotherapy interventions are employed to treat associated psychological problems of these patients.

There were of course ideological and methodological differences in the treatment delivery of these programs. We have examined the specific differences in six-month outcome among the programs, and the particular patient and treatment factors that were most associated with optimum outcome in each. While we did see evidence for potential improvement in outcome by matching particular types of patients to the specific programs, there was no evidence for any general outcome superiority in either the alcoholic or drug addict patients or from any single treatment program. Therefore, this article is concerned with the general effectiveness of substance abuse treatment across the individual treatment programs sampled and more specific program effects are reported elsewhere. All conclusions reported pertain to all the individual programs as well as the total population.

Table 1 — Background Characteristics at Admission for Treatment

	Alcoholics	Drug Addicts	Total
N	480	262	742
Age, yr	42§	31	38
Black, %	39§	52	43
White, %	60§	47	56
Education, yr	11.2	11.7	11.4
Skill or trade, %	42	40	41
Employed in past yr, %	38	36	37
Criminal convictions	2§	5	3
Incarcerated, mo	7§	15	10
Married, %	23	24	23
Living alone, %	26§	17	21
Prior alcohol or drug treatment, %	8	6	8
Problem alcohol use, yr	13§	3	9
Regular opiate use, yr	0§	7	2
Regular nonopiate use, yr	1§	4	2

§$P<.01$ by paired t test.

PROCEDURE

Admission

The admission and follow-up evaluations were based on data from the Addiction Severity Index (ASI). The ASI is a structured, 30- to 40-minute clinical research interview designed to assess problem severity in seven areas commonly affected by addiction. These areas include alcohol and drug use and medical, legal, employment, family, and psychological problems. In each of the areas, objective questions are asked, measuring the number, extent, and duration of problem symptoms in the patient's lifetime and in the past 30 days. The patient also supplies a subjective rating of the recent (past 30 days) severity and importance of each problem area. Sets of objective and subjective items from each of these areas were standardized and summed to produce composite measures that provided reliable and valid general estimates of problem severity, both at the time of admission and at follow-up.

Follow-up

All follow-up evaluations were done through ASI interviews between an independent research technician and the patient. No information from secondary sources was used and all data were monitored closely to preserve confidentiality. The validity of the follow-up data in this study was monitored through built-in consistency checks within the ASI and through spot checks on subsamples of our outpatient population, assessing the ASI data against urinalysis results, pharmacy records, and criminal justice system records. We found less than 5% inconsistency, and similar findings have been reported by other investigators studying the validity of patients' self-reports.

RESULTS

There were clear differences between the alcoholic and drug addict (Table 1) samples in age ($t=20.4$, $df=637$, $P<.01$) and radical composition ($\chi^2=27.4$, $df=1$, $P<.01$), while they were similar in years of education.

Admission data from ASI interviews indicated that the average patient started treatment with severe problems of alcohol abuse, drug abuse, or both, and moderately severe employment, family, and psychological problems. The alcoholics presented more severe medical problems, while the drug addicts showed more severe legal and employment problems. Although the samples did not differ quantitatively in the severity of the other problem areas, the nature of their particular problems within each area was generally quite different.

Patients spent an average of 51 (SD=17) days in rehabilitation treatment and there was no significant difference between the drug and alcohol group samples ($P>.10$). During

Table 2.—Change in Alcoholics and Drug Addicts From Admission to Six-Month Follow-up

	Alcoholics (N=460)		Drug Addicts (N=282)	
Criterion Composites*	Admission	6-mo Follow-up	Admission	6-mo Follow-up
Medical composite	13.6	12.8	9.4	7.0
Medical problems, days	9	8	8	5
Employment composite	10.3§	−3.8	12.1§	−2.9
Days worked	8‡	10	3§	11
Money earned, $	210§	318	80§	300
Alcohol composite	38.4§	16.2	18.1‡	13.4
Drinking, days	13§	6	8	7
Intoxicated, days	10§	3	6§	3
Drug composite	4.0‡	1.9	27.2§	5.8
Opiate use, days	0.5	0.1	12§	4
Nonopiate use, days	1.0	0.4	6‡	2
Legal composite	2.2	1.1	21.9§	9.4
Crime, days	1	0.3	9‡	3
Illegal income, $	16	11	304§	91
Family composite	10.9§	4.3	14.2§	9.6
Family problems, days	7‡	3	10‡	6
Psychological composite	13.1‡	9.5	14.1‡	9.6
Psychiatric problems, days	10§	6	11§	7

*All criteria were measured during 30 days before admission and before six month follow-up.

‡$P<.05$.

§$P<.01$.

treatment, patients received an average of 26 (SD=7) individual and 24 (SD=7) group therapy sessions. Again, no significant differences were found between the samples on either of these measures ($P>.10$). However, 65% of the alcoholic patients received a favorable discharge from treatment, as compared with only 51% of the drug addicts.

ADMISSION AND FOLLOW-UP COMPARISONS

One direct assessment of treatment outcome is a comparison of patient status measured at fixed intervals before and after treatment. In the present study, we compared patients' status during the 30-day period before admission and before the six-month follow-up, using a standard paired t test statistic. These within-group comparisons are presented for all seven criterion composites and for selected single-item criteria in Table 2. Greater scores on the composite measures indicate greater problem severity. While the absolute values of these composites (like factor scores) hold little meaning, the significance of the admission to follow-up changes are useful indicators of general improvement.

As can be seen in Table 2, there was clear evidence of significant improvement in most areas for both samples. The improvement was most significant in the target symptoms of alcohol and drug use, but was also considerable in the areas of employment and psychological function. One exception to this general improvement was the area of medical status. While there was a tendency toward problem reduction in this area for both groups, neither showed significant improvement.

BETWEEN-GROUP COMPARISONS

In an experimental design, the extent to which nontreatment factors influence patient change can be assessed through a comparison with an untreated control group. This type of design was not feasible for the present study, yet we were concerned that the amount and extent of change seen in the treated groups was inflated by nontreatment factors. We considered a between-groups comparison between the treated groups and those patients who had dropped out of treatment during the first five days of rehabilitation. This type of comparison has been reported previously,[7] but an examination of these dropout patients indicated that they had generally more severe problems at admission and clearly worse prognoses than our treated groups. Thus, the comparison appeared artificial and served only to distort further the actual effect of the treatment by providing a "straw" comparison with a poor-prognosis group.

To develop a more rigorous assessment of the actual treatment effect, we attempted to draw a meaningful comparison group from our larger population. Ideally, we wanted patients who had been comparable in pretreatment status and during-treatment performance, but had received less treatment. To this end, we chose all patients from the larger sample who had received more than five but fewer than 15 days of rehabilitation treatment, and who had received a favorable treatment discharge. While this short-term (ST) group may not be considered a control group in the conventional sense, the 98 alcoholic and 57 drug-addicted patients who met the ST criteria provided an appropriate assessment of cumulative treatment effects on several grounds. For example, ST patients had been assigned to the rehabilitation programs in the same manner and in the same proportion ($\chi^2=2.14$, $df=5$, $P>.10$) as the long-term (LT) groups. Second, the ST patients had performed as well as, or better than, the LT patients during treatment, as evidenced by their favorable discharge status. Finally, comparisons of admission status disclosed no significant differences among the ST and LT patients in the areas of age, education, or racial distribution. In fact, the ST patients had significantly fewer previous treatments ($P<.05$) and significantly lower severity ($P<.05$) in the family and social problem area. Thus, the comparison group selected was arguably conservative and adequate for estimating the actual effects of treatment.

Alcoholics

Within-group comparisons for both the ST and LT alcoholic groups are presented in Table 3. Paired t tests were again calculated for all criteria to assess the significance of the changes. As can be seen, the LT patients showed a greater number of significant improvements at a generally higher level of significance than did the ST patients. However, the ST patients also showed several areas of significant improvement.

Despite the similarity in pretreat-

Table 3. —Alcoholics

	Within-Group Comparisons				Between-Group Comparisons
	Long-term (N=262)		Short-term (N=96)		
Criterion Composites*	Admission	6-mo Follow-up	Admission	6-mo Follow-up	Posttreatment *P* Value†
Medical composite	14.0	12.2	12.8	13.0	
Medical problems, days	10	8	8	6	. . .
Employment composite	10.3§	−4.3	10.1‡	−2.7	<.01
Days worked	6§	11	7	9	<.05
Money earned, $	208§	384	215	254	<.01
Alcohol composite	37.1§	14.2	38.9§	20.6	<.01
Drinking, days	12§	5	14§	10	<.01
Intoxicated, days	9§	3	10§	3	. . .
Drug composite	3.6§	0.5	6.0	2.8	<.05
Opiate use, days	0.5	0	0.5	0	. . .
Nonopiate use, days	1.06	0.2	1.5	0.3	. . .
Legal composite	2.4‡	0.6	2.0	1.6	<.05
Crime, days	1	0	1	2	. . .
Illegal income, $	17‡	9	14	12	. . .
Family composite	11.6‡	6.0	7.4‡	3.8	
Family problems, days	8	5	6‡	2	. . .
Psychological composite	13.4‡	8.6	12.5	11.7	<.01
Psychiatric problems, days	11§	4	10	7	<.01

*All criteria were measured during 30 days before admission and before six-month follow-up.

†Covariates were age, race, number of previous treatments, and pretreatment score.

‡$P < .05$ (Student's paired *t* test).

§$P < .01$ (Student's paired *t* test).

ment status of the LT and ST groups, we thought it would be important to adjust statistically the two samples on all relevant variables before making a direct comparison of their follow-up outcomes. To this end, we performed analyses of covariance on all follow-up criteria using age, race, number of previous treatments, and the pretreatment criterion score as covariates in each analysis (last column, Table 3). As can be seen, the LT group showed significantly better employment, alcohol use, drug use, legal status, and psychological function than the ST group, despite some significant improvements by the ST alcoholics. No significant between-group differences were shown in the areas of medical health or family relations.

Drug Addicts

Within-group comparisons for the LT and ST drug addict groups are presented in Table 4. As in the case of the alcoholic sample, the LT drug addict group showed a greater number of significant within-group changes at a higher level of significance than the ST drug addicts. There is an even greater disparity between these groups than between the LT and ST alcoholics. The LT group showed significant improvements in most areas, but especially in employment and drug use. The ST group showed significant improvement in the areas of employment, drug use, and psychological function, no significant change in alcohol use or medical status, and a trend toward poorer outcome in legal status and family relations.

We again made direct comparisons of the six-month outcome data for the two groups using analysis of covariance to adjust statistically for differences in age, race, number of previous treatments, and admission scores on each criterion. The LT addicts showed significantly better posttreatment outcomes than the ST group in all seven criterion areas (last column, Table 4). The magnitude of difference between the two groups was greatest in the areas of legal status and drug and alcohol use, but moderate differences were also seen in employment, family relations and psychological status.

COMMENT

We examined the results of substance abuse treatment in a sample of male veteran alcoholics and drug addicts treated in our rehabilitation programs. Highly reliable composite measures were recorded at treatment admission in seven areas commonly affected by addiction. The same measures were again recorded on an 85% follow-up sample six months later, by independent technicians. Results provided data for three different evaluation issues.

Do Patients Improve After Substance Abuse Treatment?

Based on our within-group paired comparisons of admission and follow-up status, the answer is unequivocally "yes" for both the alcoholics and the drug addicts. Highly significant improvements were seen in both our composite criteria (indicating general problem status), and in the single-item measures.

Are Improvements Specific to Alcohol and Drug Use, or Are They More Pervasive?

Results of both the within- and between-group comparisons indicated significant improvements in most of the seven criterion areas for both samples. The most significant improvements were shown in the target areas of alcohol and drug use, but highly significant improvements were also shown in the areas of employment and family and psychological status for both samples. In addition, the drug addict group showed significant improvement in legal status. In practical terms, these improvements translated to a 54% reduction in the number of days drinking, a 67% reduction in the number of days intoxicated, and a 151% increase in earned income for the alcoholics. Further, 41% of these patients were abstinent from alcohol during the 30 days preceding follow-up. The drug addicted patients showed a 67% reduction in opiate use, a 50% reduction in stimulant use, a 67% decrease in crime days, and a 386% increase in earned income. Forty-eight percent of the patients were drug free (excepting alcohol and marijuana) during the 30 days preceding follow-up. Thus, the evidence here and from other studies[4-8] suggests that the major improvements following substance abuse treatment are in alcohol and drug use, but that there are several other areas that show moderate to major changes.

Perhaps the only clear exception to this general improvement was the area of medical status or physical

Table 4.—Drug Addicts

	Within-Group Comparisons				Between-Group Comparisons
	Long-term (N=[illegible])		Short-term (N=[illegible])		
Criterion Composites*	Admission	6-mo Follow-up	Admission	6-mo Follow-up	Posttreatment P Values†
Medical composite	9.9	5.1	9.1	8.8	<.05
Medical problems, days	6	3	9	6	...
Employment composite	12.4‡	−2.7	11.8‡	−3.8	<.05
Days worked	[illegible]	10	44	18	...
Money earned, $	885§	341	771‡	209	<.05
Alcohol composite	17.0§	11.9	19.4	19.0	<.01
Drinking, days	[illegible]	8	9	11	[illegible]
Intoxicated, days	[illegible]	6	0	6	[illegible]
Drug composite	27.0§	3.0	26.1‡	14.8	<.01
Opiate use, days	120§	0	11‡	7	<.01
Nonopiate use, days	50	1	8	6	<.01
Legal composite	20.1§	3.0	22.8	23.2	<.01
Crime, days	9§	1	[illegible]	6	<.05
Illegal income, $	3389§	23	3391	188	<.05
Family composite	15.1‡	9.4	9.8	9.7	<.05
Family problems, days	11‡	5	8	6	<.05
Psychological composite	14.2§	8.4	13.9‡	11.8	<.05
Psychiatric problems, days	11§	7	12‡	7	...

*All criteria were measured during 30 days before admission and before six-month follow-up.

†Covariates were age, race, number of previous treatments, and pretreatment score.

‡P<.05 (Student's paired t test).

§P<.01 (Student's paired t test).

health. We have no reason to believe that medical treatment was particularly poor for these patients but, rather, it is likely that the physical problems of these patients were underreported at treatment admission (because of the anesthetic effects of drugs and alcohol) and that the majority of the medical problems that were reported by these patients were chronic in nature, with little chance of significant remission.

Is Patient Improvement a Result of Treatment?

We recognized that despite the significant improvements shown in the alcoholic and drug addict samples, there was no clear evidence that the changes were a result of the treatment process. We needed a comparison group as a control for nontreatment factors, such as maturation, spontaneous remission, and regression,[1-4] that can account for much of the observed improvements. Ideally, this comparison group would be selected from the same population as the treated subjects, with equal exposure to nontreatment factors but less exposure to treatment. We therefore selected all subjects from the treated population who had received a favorable discharge but had less than 15 days of treatment. The subjects for this ST group were not selected randomly but they were assigned to treatment on the same basis (see "Subjects" section) and in the same proportion as the LT subjects. Thus, it is not possible to argue that the ST patients had entered into less-favored treatments or were assigned differently.

These ST patients may have had less motivation, thereby accounting for their shorter time in treatment. However, they completed five to 14 days of rehabilitation therapy at their assigned program and all received favorable discharges, indicating that they left with adequate discharge planning and were not ejected for disciplinary reasons. Finally, there was no evidence to suggest that these patients had a poorer prognosis at the time of admission or at discharge. We cannot rule out completely the possibility of differences in motivation between the two groups; however, our previous work[11] has shown that neither staff or patient ratings of motivation, nor voluntary vs involuntary admission status is related to length of time in treatment, type of discharge, or treatment performance. We do not contend that the ST group is the optimum control group, only that it is a valid and conservative comparison to the LT group, providing a useful estimate of actual treatment effects.

The between-groups (LT vs ST) analyses of covariance included adjustments for differences in age, race, previous treatments, and each admission criterion score, providing the most direct test possible of the extent to which more treatment was associated with better outcome. The results from these analyses showed significantly better posttreatment status in virtually all areas for the LT patients, especially in the areas of employment, drug and alcohol use, legal status, and psychological function. It is important to note that although the ST groups generally showed some positive change, the LT groups showed significantly better outcomes and larger treatment effects in comparison.

After evaluating the six-month outcome of alcohol and drug abuse treatment in seven different areas, using both within-group and between-group comparisons, the findings were consistent across areas, across alcohol and drug samples, and across the six treatment programs studied. Furthermore, these findings were consistent with our previous evaluation research and with the substantial body of data from other large-scale evaluation studies of substance abuse treatment.[4-6] While no single finding is by itself definitive, we conclude, on the basis of the combined results, that the most parsimonious explanation for these findings is that substance abuse treatment is effective in producing significant, pervasive, and sustained positive change in the lives of these patients.

We have not examined the numerous differences among patients and among treatment programs, or how they interact to produce optimum therapeutic matching. Furthermore, we have not discussed the particular factors during the treatment process that appear to be most closely associated with optimum outcome. These are particularly complex theoretical and methodological issues, which we have examined at length in separate reports.[9-11] Unfortunately, this study, like most other evaluations, has focused on male patients. It will therefore be important for future studies to examine these issues among female populations.

It is important to note that we have not used the word "cure" in this evaluation of treatment effectiveness. It is our feeling that discussions of cure rates or of abstinence percentages give artificial simplicity to what is arguably the most complex, heterogeneous, and chronic health problem in the world. Substance abuse cannot be conceptualized as simply the psychophysiological dependence on drugs or alcohol. If this were true, then the goal of treatment would be simple and direct: the detoxification of the dependent patient. In fact, there are now a number of methods available for rapid and safe detoxification from virtually all drugs. However, detoxification by itself is clearly an ineffective treatment, generally resulting in relapse within one month.[9,13]

Our past work and our clinical experience indicate that substance abuse occurs in persons who commonly have associated problems in the areas of physical health, employment, legal status, family relations, or psychological function. Regardless of whether these associated problems preceded or resulted from the chemical dependence, they can have a profound effect on the patient's response during treatment and can leave him chronically susceptible to relapse following treatment. It is comparatively easy to eliminate at least the acute signs of a patient's psychophysiological tolerance to alcohol or drugs through detoxification alone. It is much more difficult to sustain that condition through improvements in the constellation of associated problems. Yet, the data presented here and elsewhere suggest that substance abuse treatment can be effective in this larger goal.

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Increased Effectiveness of Substance Abuse Treatment

A Prospective Study of Patient-Treatment "Matching"

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An earlier study retrospectively evaluated the effectiveness of six separate substance abuse treatment programs and generated a set of hypotheses for matching patients to the most appropriate programs. In the present study, these predictors and the matching strategy were tested in a prospective design, using the same treatment programs and a new sample of 130 alcohol- and 256 drug-dependent patients. The new group of patients who *were* treated in their predicted program (matched patients) were compared with those patients from the same sample who *were not* treated in their predicted program (mismatched patients). Treatment staff *were not* apprised of the matching criteria or which patients were matched, thus permitting an experimental test of the predictions. Results indicated superior performance during treatment and an average of 19 per cent better 6-month outcomes for the matched patients than for their mismatched counterparts. The matching effect was seen in both the alcohol- and drug-dependent samples and in all treatment programs. The authors discuss the application of these findings to other types of patients and treatments in substance abuse and other fields of psychiatry.

It has been traditional to conclude evaluations of drug and alcohol abuse treatment programs with the observation that no treatment is effective for all patients, and with the hope that methodologies might be developed to allow for more appropriate "matching" of patients and treatments. Unfortunately, although several attempts at matching have been tried, there are to date few indications of success (1, 2, 5, 17).

Like many others in the field, our group has attempted to find the patient characteristics that were most related to favorable outcome and then use this information to assign patients to the most appropriate treatments. Initial reports described the design of our matching study (11) and the evaluation instrument which we developed to provide the admission and 6-month follow-up data for this project (13). Subsequent studies reported a 6-month follow-up evaluation of 742 alcohol and drug-dependent patients treated in our six-program network (15), and detailed the patient characteristics which were found to be most predictive of outcome in these programs, based upon *retrospective* analyses (14).

In this report, we discuss the results of a *prospective* patient-treatment matching study that has been employed with a new sample of 476 male, veteran, alcohol and drug abuse patients assigned to treatment in our six rehabilitation programs using these predictors. The theoretical and methodological bases for this strategy are discussed as well as the broader application in psychiatric treatment research.

Retrospective Study—Predictors of Patient-Program "Matches"

The retrospective portion of this work involved a sample of 742 male veterans (460 alcohol-dependent, 282 drug-dependent) treated in the six-program Veterans Administration treatment network during 1978 (14). We will hereafter refer to these data as the 1978 cohort. All patients were evaluated at the start of treatment and again at follow-up 6 months later, using the Addiction Severity Index (ASI) (13). These data were analyzed to determine whether there were any patient-program matches which produced particularly favorable or unfavorable results.

Our first predictive analyses were performed on the entire alcohol- and drug-dependent patient samples and, like other studies, no significant patient-program matches were revealed. However, these initial analyses indicated that a 10-point, global rating of patient's psychiatric severity, estimated at admission, was the single best predictor of most outcome measures for

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both alcohol- and drug-dependent samples (13, 14). This finding prompted us to divide each of the alcohol and drug abuse samples into LOW, MID, and HIGH psychiatric severity groups and perform the predictive analyses again on each of these six groups.

Results of this second round of predictive analyses revealed significant relationships which had been masked in the unstratified samples. Alcohol- or drug-dependent patients with LOW psychiatric severity at admission generally showed significant improvement and the best outcomes *regardless* of which treatment program they entered. Conversely, patients in both samples with HIGH psychiatric severity at admission showed little improvement and uniformly poor outcomes *regardless* of which program they entered (9, 12). Thus, for very different reasons, there was no evidence of differential effectiveness from patient-program matching in these groups. Results in the MID severity groups (60 per cent of the population) did show evidence for significantly better outcome from patient-program matching, and different, specific factors were predictive in each program (14).

We found these results to be generally consistent with the literature and with our clinical impressions. However, they were retrospective conclusions based upon a series of statistical procedures and we were not sure of their replicability or utility. Thus, it seemed necessary to incorporate these *retrospective* data into workable treatment assignment criteria and to test them in a *prospective* study.

Prospective Study—Matched (M) *vs.* Mismatched (MM) Patients

Subjects

Subjects were all male veterans who applied for substance abuse rehabilitation treatment at either the Philadelphia or Coatesville Veterans Administration (VA) Medical Centers during the first 9 months of 1980.

As in the retrospective study, all patients were evaluated during an initial 5-day period of detoxification or stabilization. We initially evaluated 649 patients (238 alcohol- and 411 drug-dependent) during this period. Approximately 20 per cent of each group (no significant difference, $p > .10$) dropped out before completion of this initial phase, leaving 189 alcohol- and 321 drug-dependent patients eligible for assignment to a rehabilitation program and inclusion in the study. Six-month follow-up efforts were successful with 94 per cent of these eligible subjects, leaving 476 patients (178 alcohol-, 298 drug-dependent) with complete data.

Treatment Programs

The substance abuse treatment network of the \ in Philadelphia consists of four inpatient (two alcob one drug, one combined) therapeutic community pr grams at the Coatesville VA Medical Center, pl outpatient alcohol and drug abuse clinics at the Ph adelphia VA Medical Center. These same prograr were studied both in 1978 and 1980. There we changes in personnel during this period, with three the six programs changing their directors. Furthe more, due to construction at Coatesville, there was move to different quarters for three programs. Ho ever, no program changed its treatment orientation its program length.

Following are brief descriptions of the programs; f more complete information see Gottheil *et al.* (7)

Alcohol Therapeutic Community (ATC). A 60-da inpatient therapeutic community based upon the pri ciples of Alcoholics Anonymous (AA) and transa tional analysis. The staff conducts small group the apy four times weekly.

Fixed-Interval Drinking Decisions (FIDD). A r search program designed to examine and treat alc holism in the presence of alcohol. The 6-week tre ment cycle consists of two 1-week alcohol-free perio and a 4-week drinking decisions phase in which t ounces of 80 proof alcohol are available hourly, a the patients have the opportunity to decide wheth or not to drink. Group and individual therapies a offered daily.

Combined Treatment (COMB). A 60-day inpatie program which delivers intensive addiction mana ment therapy to *both* alcoholics and drug addict Treatment is based upon principles of AA and th therapeutic community with emphasis on ancillar individual therapy and educational material.

Drug Abuse Therapeutic Community (DTC). Offe personal and social treatment in a 60-day progra designed to "habilitate" the patient to society us individual and group therapy, educational and voc tional counseling. Special emphasis is placed up encounter therapy, the social structure of a self-go erning therapeutic community, and abstinence fro all drugs, including psychotropic medications.

Alcohol Outpatient (AOP). A variable-length tre ment program that concentrates upon the medic psychological, and social problems of alcoholics. Bo individual and group psychotherapy are employed e tensively as well as referrals to AA and social agenci

Methadone Maintenance. Offers methadone ma tenance, in combination with a full program of medic care, psychiatric and social work counseling. Chem therapy and individual therapy are employed to tre associated psychological problems of these patients

Treatment Matching Strategy

Decision Levels

We developed a treatment assignment decision hierarchy using the seven, 10-point severity ratings obtained from the admission ASI. This strategy was based on the retrospective findings from the 1978 cohort and was used to match substance abuse patients to the six programs in our treatment network. The decision hierarchy had three levels.

I. Alcohol- or drug-dependent. The initial determination was whether the admitted patient was alcohol- or drug-dependent. In cases of dual addiction, the patient was considered drug-dependent.

II. Psychiatric severity group. The 10-point psychiatric severity rating on the ASI was used to assign patients to LOW (0 to 2), MID (3 to 6), or HIGH (7 to 9) severity groups. These were the same intervals used in the retrospective 1978 study (14). This psychiatric severity rating is not diagnostic but provides a reliable and valid general estimate of psychiatric impairment (13, 14) similar to the Health Sickness Rating Scale (10) or the General Adjustment Scale on Schedule for Affective Disorders and Schizophrenia—Lifetime Version (6).

Patients in the LOW psychiatric severity groups were generally asymptomatic and had no history of psychiatric problems. MID severity patients generally reported significant symptoms of anxiety, depression, and/or confusion but no recurrent history of such problems. HIGH severity patients usually reported pronounced symptoms such as intense anxiety, suicidal ideation, paranoia, and/or serious confusion/disorientation, and usually had a history of recurring symptoms (9, 12).

III. Severity of other problems. The ASI also provided independent 10-point ratings of severity in six other problem areas that are often disturbed in patients with alcohol and drug dependence. These were medical condition, employment, drug use, alcohol use, legal status, and family relations.

Decision Strategy

All patients who entered the treatment network were evaluated during a standard 5-day detoxification or stabilization period. Patients who wanted additional rehabilitation treatment after this evaluation phase were eligible for assignment to the most appropriate rehabilitation program within our six-program network. The actual program assignment strategy is illustrated in Tables 1 and 2. The strategy is based upon a decision-tree model with the most important factors receiving the earliest consideration in the assignment. In general, patients in the LOW psychiatric severity groups were recommended for outpatient treatment because this was considerably less expensive and because the retrospective data indicated that approximately equal outcomes would result from all treatments. The one exception to this strategy was LOW severity patients with significant family and/or employment problems. The original data suggested that these problems might impair the effectiveness of outpatient treatment; thus an inpatient program was recommended in these cases.

TABLE 1

Program Assignment Decision Criteria

Alcohol-Dependent Patients ($N = 179$)

If psychiatric severity is low (0–1)—$N = 47$ and:
  Employment severity greater than 6, then—any inpatient; not AOP
    Matched = 31 (66%), mismatched = 16 (34%)

If psychiatric severity is MID (2–5)—$N = 83$ and:
  Legal severity greater than 4, then—COMB, AOP, not FIDD or ATC
  Employment severity greater than 4, then—any inpatient; not AOP
  Family severity greater than 5, then—FIDD, ATC; not COMB or AOP
    Matched = 49 (60%), mismatched = 34 (40%)

If psychiatric severity is high (6–9)—$N = 49$
  Try to transfer to psychiatric ward if possible
  No appropriate program
    Matched = 0 (0%), mismatched = 49 (100%)

TABLE 2

Program Assignment Decision Criteria

Drug-Dependent Patients ($N = 298$)

If psychiatric severity is low (0–2)—$N = 90$ and:
  Employment severity and/or family severity greater than 5, then—COMB, DTC, not MM[a]
    Matched = 56 (62%), mismatched = 34 (38%)

If psychiatric severity is MID (3–6)—$N = 166$ and:
  Family severity and/or employment severity greater than 4, then—COMB, DTC; not MM
  Medical severity greater than 4, then—COMB, MM; not DTC
  Drug abuse severity greater than 6, then—DTC, MM; not COMB
    Matched = 68 (41%), mismatched = 98 (59%)

If psychiatric severity is high (7–9)$N = 42$)
  Try to transfer to psychiatric ward if possible
  No appropriate program
    Matched = 0 (0%); mismatched = 42 (100%)

[a] MM, Methadone Maintenance.

Patients in the HIGH psychiatric severity groups were recommended for psychiatric treatment at either our inpatient wards or at an associated community clinic. The retrospective data suggested that these patients received relatively little benefit from any of the programs, generally at great expense of staff time and effort (9, 12). Thus, these patients were considered mismatched in all six programs. However, these patients *were treated* within the network if no appropriate referral could be made.

Patients in the MID psychiatric severity groups were assigned to particular treatment programs based upon the pattern and severity of their other treatment problems at the time of admission. A description of the specific factors which were used in the assignment of these MID severity patients is included for the alcohol-dependent patients in Table 1 and for the drug-dependent patients in Table 2. These factors are listed in order of their weight in the decision strategy.

Implementing the Assignment Strategy

Patients seeking treatment within the six-program network could be admitted directly to either of the two outpatient programs at Philadelphia, or to a central intake facility for inpatient treatment at Coatesville. Patients who entered treatment at either of the outpatient programs were stabilized and evaluated. Those who were considered most appropriate for an inpatient program (based upon the study criteria) were referred to the central intake facility at Coatesville. At this facility, patients who had originally entered, or had been referred to treatment there, were screened and assigned to one of the four inpatient programs by one author (K. A. D.) using the study criteria. Our intention was that all patients would be assigned to the treatment programs based only upon these criteria. However, several factors complicated the procedure and resulted in only 53 per cent of the patients being "matched" to the appropriate treatments (48 per cent, drug; 62 per cent, alcohol). The major reason for not matching was lack of bed availability or treatment slot at the appropriate program (approximately 27 per cent). Patient's refusal or inability to accept assignment accounted for approximately 13 per cent of the mismatches, while simple assignment errors or clinical overriding of the decision strategy accounted for approximately 7 per cent of mismatches. It is important to note that *staff members* in each of the programs *were unaware of which patients were "matched" (M) and which were "mismatched" (MM)*. Furthermore, no patient was refused treatment.

Thus, in the analyses that follow, we have compared the during-treatment and 6-month follow-up performance of those patients who were treated in the program which was predicted to be best for them (matched); and those patients who were treated in a program other than the one which was predicted to be best for them (mismatched). Given essential similarity in the pretreatment status of the two groups, the fact that the treatment programs were the same for all patients, and the fact that treatment staff were unaware of the grouping distinction, better performance by the matched (M) subjects will be evidence suggestive that the matching procedure was effective.

Data Collection Procedure

Admission and follow-up data were recorded on all subjects by "blind" research technicians using the ASI (13). All follow-ups were completed in person or over the phone, 6 months (±2 weeks) following treatment admission. No data were taken from relatives or associates of the patient. The validity of the ASI data was monitored in two ways. First, there are several checks built into the ASI which can catch inconsistencies in the reported data. Second, the ASI data were verified in a 15 per cent sample of patients by checking the reported data against pay stubs, arrest records, breathalyzer and urinalysis results. We are satisfied that there was no general tendency to falsify these self-reports and several other investigators have reached similar conclusions (3, 18). Ninety-four per cent of the attempted follow-ups were successful and the completion rates were not different between the alcohol and drug abuse samples or among the six treatment groups ($p > .10$).

During-treatment measures of the length of stay and type of discharge were also recorded on all patients. In addition, at the time of discharge, treatment staff (who were blind to the study) were asked to rate the motivation for treatment and the appropriateness (for the particular program) of each patient, using a 4-point scale.

Outcome Criteria

As in the retrospective stage of the project, we assessed outcome in seven areas commonly associated with addiction. These included medical condition, employment, alcohol use, drug use, legal status, family relations, and psychiatric adjustment. As before, we developed factor scores in each of these areas from sets of interrelated objective items from the ASI (14, 15). These items were standardized and summed to create the factor scores. A description of the actual items included in each factor and the standard procedure used to derive the factor score is available from the senior author. Each of these composites was tested for internal consistency (reliability) using Cronbach's alpha (4) and all factors showed coefficients of .65 or higher ($p < .05$). In addition to the general measures of outcome status in these seven areas, we also analyzed 12 single-item measures (*e.g.*, days of drug use, employment earnings, etc.) in order to make the results more interpretable.

Results

Our initial analyses compared the during-treatment performance and 6-month follow-up outcomes of the matched and mismatched patients in both the alcohol- and drug-dependent samples. The during-treatment comparisons for both samples indicated that the M patients were rated as significantly ($p < .05$) more motivated for treatment, they stayed in treatment longer, and had fewer irregular discharges than the MM patients. Analyses of covariance on the 6-month outcome measures, adjusting the groups for admission differences in age, race, prior treatments, and the admission criterion score, indicated better outcomes for M patients on 17 of the 19 outcome variables and 10 of these comparisons were significant ($p < .05$). In fact, when all follow-up measures were averaged, the M patients shows 27 per cent better outcome than the MM patients.

Excluding High Severity Patients

It was possible that the results from these initial analyses might be accounted for by the greater proportion of HIGH severity patients in the mismatched group. The results of our retrospective (1978) analyses suggested that these patients responded poorly to all of the available alcohol or drug abuse treatments (see 9, 12). Thus, in our 1980 cohort, we considered the HIGH subsamples to be mismatched in all programs. Therefore, it was possible that the comparatively poorer performance of the mismatched patients might have been due to the HIGH severity subgroup. In an attempt to examine this issue in more detail, we eliminated all HIGH severity patients, reanalyzed the data, and obtained the following results.

Alcohol-Dependent Patients

Even after the HIGH severity patients were excluded, the during-treatment data (Table 3, first column) from the LOW and MID subgroups still showed that the matched alcohol-dependent patients were rated as significantly more motivated for treatment ($p < .01$), stayed in treatment longer ($p < .05$), and had a higher proportion of favorable discharges than their mismatched counterparts.

TABLE 3

During-Treatment Performance of Matched and Mismatched Substance Abuse Patients Excluding Those with Severe Psychiatric Problems

	Alcohol-Dependent		Drug-Dependent	
	Matched ($N = 80$)	Mismatched ($N = 80$)	Matched ($N = 124$)	Mismatched ($N = 122$)
Motivation				
% Resistant to treatment	25*	38	31*	23
% Motivated for treatment	61**	46	48*	36
Days of treatment	80*	52	111	100
Discharge				
% Favorably discharged	67*	46	29	25
% Irregular discharge	33	45	27*	43
% Considered appropriate for treatment program	82	88	84	75

* $p < .05$; ** $p < .01$.

Analyses of covariance were performed on the 6-month follow-up measures to compare the post-treatment status of the two groups (see Table 4, first column). These analyses adjusted the two groups for pretreatment differences in age, race, treatments, and the admission criterion score. The M patients showed significantly ($p < .05$) better 6-month outcomes in the areas of medical condition, employment, drug use, legal status, and family relations. In summary, 17 of the 19 follow-up comparisons showed better outcome status in the matched patients and eight of these comparisions were statistically significant ($p < .05$). These results were similar when the MID and LOW subgroups were analyzed separately.

TABLE 4

Six-Month Follow-up Performance of Matched and Mismatched Substance Abuse Patients, Excluding Those with Severe Psychiatric Problems

Criteria[a]	Alcoholics			Drug Addicts		
	Matched ($N = 80$)		Mismatched ($N = 80$)	Matched ($N = 124$)		Mismatched ($N = 122$)
Medical factor	275	*	350	302	*	248
Days of medical problems	9		8	6		7
Employment factor	357	**	437	300	**	471
Days worked	10		8	12	*	7
Money earned	380	**	172	469	**	226
Welfare income	19		25	36	*	64
Alcohol factor	217		186	72		80
Days drinking	7		7	5		6
Days intoxicated	3		4	1		2
Drug factor	11	*	33	129	*	153
Days opiate use	0		2	5		7
Days nonopiate use	2	*	8	8		6
Legal factor	24	**	101	75	*	88
Days of crime	1		2	3		3
Illegal income	6	**	32	64	*	132
Family factor	210	*	263	205	*	251
Days of family problems	2		4	2		4
Psychiatric factor	121		134	128	*	186
Days of psychiatric problems	5		6	5		6

[a] All criteria were measured during the 30-day periods preceding admission and preceding 6-month follow-up. Higher factor scores indicate greater problem severity.

* $p < .05$; ** $p < .01$ by analyses of covariance. Covariates were age, race, prior treatments, and the admission criterion score.

Drug-Dependent Patients

The during-treatment data from the drug-dependent sample, excluding HIGH severity patients, are presented in the last column of Table 3. The results indicated that here too, the M patients were rated as significantly more motivated for treatment ($p < .05$) than the MM group, and had significantly fewer irregular discharges ($p < .05$).

The 6-month outcomes of the M and MM groups were also compared using analysis of covariance procedures to adjust for pretreatment differences (see Table 4, last columns). Again, results indicated that the M group had better outcomes on all 19 variables than the MM patients. Results were significant ($p < .05$) in the areas of medical status, employment, drug use, illegal income, and psychiatric status. Again, these results were quite similar when the MID and LOW subgroups were analyzed separately.

Thus, the data from both the alcohol- and drug-dependent samples indicated better treatment responses and 6-month outcome in the matched patients than the mismatched patients.

Excluding Program Artifacts

It remained possible that the more favorable results among matched patients might be due to *only one or two programs*, with less than satisfactory results possible from the other programs. We therefore analyzed differences in during-treatment performance, and adjusted follow-up outcomes for M and MM subjects from each of four programs. Unfortunately, the total number of subjects was too low in the FIDD program and the number of matched subjects was too low in the COMB program, to permit meaningful analysis; thus these program samples were not analyzed and the remaining four are presented.

The during-treatment analyses showed that M patients were significantly ($p < .05$) more likely to be rated as appropriate for their assigned treatment in three of the four programs. Furthermore staff from all four programs rated a larger proportion of matched patients as motivated for treatment (significantly so in the methadone maintenance program). There was little difference in length of stay between M and MM patients in the two inpatient programs, but the length of stay was significantly ($p < .05$) longer for the matched patients in each of the two outpatient programs. The proportion of patients that received a favorable discharge was not significantly different between M and MM patients in any program, although again, the outpatient programs had a tendency ($p < .10$) to show better performance for the matched patients.

Analyses of adjusted 6-month outcomes are presented for M and MM groups by treatment program in Table 5. There was considerable evidence of improvement in several areas for both matched and mismatched patients in all four programs. However, comparisons of 6-month outcomes between the matched and mismatched groups showed pervasive evidence of better status in the matched patients (see Table 5). As can be seen, only 10 of the 76 comparisons (19 criteria × 4 programs) showed better outcomes for the mismatched patients and only three of these were significant. In contrast, 66 of the 76 comparisons in the four treatment programs showed better outcomes for the matched patients and 29 of these were significant. Therefore, we conclude that the better during-treatment performance and 6-month outcomes seen by the matched patients in the unstratified samples were largely consistent across all the treatment programs examined.

Discussion

Two major findings resulted from the present study. First, the data from both the 1978 and 1980 patient cohorts and for both the alcohol- and drug-dependent samples clearly indicated that substance abuse rehabilitation was effective *even without modification of treatment assignment procedures*. The impact of this finding was given added weight by the consistency in type, magnitude, and distribution of improvements shown by these cohorts in 1978 and 1980 (15).

Alcohol-dependent patients who remained in rehabilitation treatment for at least 15 days showed decreases of 67 per cent in their drinking, reductions of 38 per cent and 61 per cent, respectively, in their family and psychiatric problems, and an increase of 92 per cent in earned income 6 months after treatment admission. Similarly, drug-dependent patients evaluated during the same time periods showed decreases of 67 per cent in opiate use, 50 per cent in nonopiate use, 67 per cent in criminal activity, and an increase of 20 per cent in earned income.

It should be noted that patients were followed up 6 months after their *admission* to treatment. For this reason, the time between treatment discharge and follow-up was not equal for all patients. We examined the relationships between time out of treatment and outcome status on all criterion measures, and no significant ($p > .10$) correlations were shown for any of the groups. The relatively short duration of the follow-up interval may have maximized the treatment effects and it is possible that some of the improvement shown would be reduced if longer follow-up intervals were examined. While this possibility cannot be discounted, there is evidence that significant post-treatment gains do continue in substance abuse patients at 6 months, 1 year, and even 24 months after treatment (8).

A second major finding was that the *effectiveness of treatment was improved by matching* patients to the most appropriate programs within the treatment network. Patients who were assigned and admitted to the most appropriate program (matched patients) had significantly better adjustment during treatment, showed more improvements, and had generally better 6-month outcomes than patients who were treated in the *same programs* but were predicted to have a different optimum treatment assignment (mismatched patients). In fact, the overall outcome of the matched patients (averaged across all criteria) was 19 per cent

TABLE 5

Six-Month Follow-up Performance of Matched and Mismatched Substance Abuse Patients in Four Treatment Programs

Criteria[a]	Inpatient Alcohol T.C.[b]			Inpatient Drug T.C.			Outpatient Alcohol Rehabilitation			Methadone Maintenance		
	Matched (N = 64)		Mismatched (N = 41)	Matched (N = 40)		Mismatched (N = 37)	Matched (N = 21)		Mismatched (N = 26)	Matched (N = 63)		Mismatched (N = 81)
Medical factor	314		225	132	*	249	387	*	206	187	*	196
Days of medical problems	11		8	3		10	11		6	5		8
Employment factor	306		387	332	*	375	353		364	327	**	518
Days worked	8		7	11		9	9		9	14	*	8
Money earned	224	*	308	231		216	319	*	206	656	**	281
Welfare income	30		31	18	*	31	81		48	40	*	87
Alcohol factor	190	*	206	76	**	128	125		129	77		72
Days drinking	6		6	5		6	7		7	7		6
Days intoxicated	4	*	3	2		3	5		4	2		2
Drug factor	14	**	31	71	**	104	14	*	20	169		189
Days opiate use	1		0	3		5	0		1	7		10
Days nonopiate use	3		5	1		3	1	*	4	3	*	6
Legal factor	28	*	83	131		140	4	**	29	64	*	108
Days of crime	1		0	2		2	0		1	2		2
Illegal crime	17		10	25	*	65	0	*	30	99	*	130
Family factor	190	*	223	211	*	274	208		204	206	*	252
Days of family problems	1		2	1		3	2		2	2		3
Psychiatric factor	144	**	228	110	**	186	96		117	117	*	184
Days of psychiatric problems	2		5	5	**	12	4		6	4		7

[a] All criteria were measured during the 30-day periods preceding admission and preceding 6-month follow-up. Higher factor scores indicate greater problem severity.

[b] T.C., therapeutic community.

[c] $p < .05$; ** $p < .01$ by analysis of covariance. Covariates were age, prior treatments, race, and the admission criterion score.

better than that of the mismatched patients, even when HIGH severity patients were excluded. *This "matching" effect was shown in both the alcohol- and drug-dependent samples, in both LOW and MID severity groups, and in all of the treatment programs sampled.* Thus, the effect was not isolated to a particular type of patient or treatment. This finding indicates that the same factors which were predictive of patient outcome in 1978 were again predictive in 1980. This is noteworthy in view of the poor history of replicated results in treatment outcome evaluations and in view of the changes in the patient population and the treatment program personnel which took place during those years.

Alternative Explanations

It is important to question whether any factor other than the matching strategy could have been responsible for the significant differences in outcome. To this end, we examined the demographic characteristics, treatment history, and admission status variables of the M and MM patients in each treatment program under the possibility that the two groups were different on some general factor related to outcome. As the matching strategy was designed to differentiate patients on the specific factors which had been predicted to be important to treatment outcome in each program, there were some expected differences. However, there were *no general* qualities or factors which were significantly different between M and MM patients in more than two of the six programs (once the HIGH psychiatric severity patients were removed). Furthermore, the few qualities which were different between the M and MM patients were not reliably related to follow-up status across all outcome criteria or across all programs. For example, a greater number of prior treatment attempts was negatively associated with favorable outcome in two programs and positively associated with most outcome criteria in two other programs.

With regard to the possibility that the M and MM patients received differential treatments, it should be clear that both groups were treated in the same programs by personnel who were blind to the matching distinctions. Thus, it is unlikely that M patients received more favored treatments. Furthermore, it is unlikely that MM patients were resentful about their treatment assignment. In most cases of mismatch, the patient had chosen that particular program. In fact, it was more often the case that the *matched* patients were directed to a program which they originally had *not* planned to enter. This raises the possibility that the MM patients were less compliant and possibly less motivated than M patients. As indicated, only 13 per cent of patients were mismatched due to their refusal to accept reassignment and more than half of these were in the HIGH severity group. As the matching effect was demonstrated without this group (Tables 1 and 2), we conclude that even if noncompliance was a factor, it cannot fully account for the observed differences in outcome.

Implications

The finding that patients can be effectively matched to the most appropriate program within a treatment network is potentially important for health care providers both within the field of addiction and in general psychiatry. The cost-effectiveness of patient-program matching was particularly significant as the *added effectiveness of treatment required no additional facilities, equipment, or personnel.* Furthermore unlike many other cost-saving modifications, the matching process was generally well accepted by both patients and staff. Patients were assigned to treatments that had the best record of dealing with their particular problems and treatment staff received the patients with whom they had the most success.

We are certain that a key reason for the success of the present matching attempt has been the inclusion of a global estimate of admission psychiatric severity as an outcome predictor. This measure has been a robust predictor of outcome from other treatments with this population (19) and with general psychiatric patients receiving psychotherapy (16). We think that a global estimate of psychiatric impairment is potentially the best general predictor of treatment outcome across many patient groups and treatment types in psychiatry. Thus we recommend this variable as part of any treatment matching procedure.

In the present study, LOW severity patients showed the best outcomes regardless of their treatment assignment. These patients can almost always be assigned to outpatient programs at a *savings of more than $53.00 per patient, per day, or an average savings of more than $3700.00 per patient* over the normal course of treatment. Conversely, both the 1978 and 1980 data indicated that HIGH severity patients (both alcohol- and drug-dependent) had the poorest outcomes, regardless of the programs in which they were treated. In fact, these high-severity patients were more than twice as likely to return to hospitalization (often via the emergency room) than the other patients, during the 6-month follow-up interval. We have examined this group of patients in a series of studies and have come to believe that appropriate psychiatric interventions should be used as part of their substance abuse treatment.

The finding that the substance abuse patients in this population who had more severe employment and/or family problems were less suited to outpatient treatment is logical and consistent with clinical experience. We believe that an extended inpatient rehabilitation program for the patients extricates them from a damaging environment, allows them to concentrate upon the rehabilitation process, and permits the families to re-evaluate objectively their contribution to the patient's condition. Thus, we believe that these factors are also potentially important to other treatment matching efforts, at least for substance abuse patients.

The more specific factors which were associated with favorable outcomes in this study (*e.g.*, medical condition, drug history) may be peculiar to the particular programs evaluated. We do not contend that these factors are *the* outcome predictors for other patient samples, only that they were effective in this population, within these programs, and at this time. We anticipate that as the programs and/or the patient samples evolve, these more specific predictors may also change. However, we believe that the present methodology will be effective in detecting those changes and that our ongoing "matching" strategy will continue to be helpful in optimizing outcome.

In this regard, it is important to note a significant omission within the present study. We have concentrated our efforts on obtaining a detailed and comprehensive description of the patients' treatment problems and have paid little attention to the equally important task of obtaining an equivalent description of the treatment process in each program. Thus, we have been able to show that certain types of patients have better outcomes in certain kinds of programs but we are not sure why. In future studies we will attempt to characterize the actual treatment processes so that we may begin to understand the reasons underlying favorable and unfavorable patient-program matches.

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Legal Interventions to Reduce Drunken Driving and Related Fatalities Among Youthful Drivers

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ABSTRACT

From 1980 to 1985 over 400 local chapters of citizens groups concerned with drunken driving were founded nationwide, media coverage of the drunken driving problem increased exponentially, and over 500 legislative changes were passed to reduce fatal crashes involving drunken drivers. The most common changes were increases in the legal drinking age and passage of per se legislation to increase convictions. Forty-nine states have now raised the age to 21 and over 30 states passed per se laws bringing the national total to over 40. Drinking age increases have generally been credited with 10 to 15% declines in fatal crashes in the targeted age groups, but effects are variable from state to state and many teens circumvent these laws by having others purchase alcohol for them or by purchasing from liquor outlets that do not ask for age identification. Per se laws have not been as extensively studied. International experience suggests these laws can produce short term fatal crash declines, but lack of police and court enforcement compromises long-term reduction in drunken driving and fatal crashes. In Maine a 1981 per se law produced initial fatal crash declines, particularly among young drivers. However, these outcomes were short-lived because the public did not perceive an increase in the likelihood that drunken drivers would be stopped by police. Also, police speed enforcement declined during the post-law period.

Nationwide from 1980 to 1985 fatal crashes involving intoxicated drivers declined more than other fatal crashes especially among teenage drivers. Media attention to drunken driving, formation of new citizen groups concerned with the problem, and the numbers of new drunken driving laws passed peaked between 1983 and 1985. But from 1985 to 1986 alcohol related traffic fatalities increased 7% among all age groups and 14% among teenagers 15 to 17 years of age. Other traffic fatalities rose only 3%.

Introduction

The Drunken Driving Problem in the U.S.

During the first half of the 1980s the U.S. experienced an unprecedented emergence of public concern about the problems posed by drunken drivers. In 1982 approximately 39% of the drivers in fatal crashes and 59% of all traffic fatalities involved a driver or pedestrian who had been drinking (Fell, 1987). Laboratory studies of driver performance, case series analyses of blood alcohol levels of intoxicated drivers and roadside survey studies, including comparisons of drivers in fatal crashes and those driving at similar times and locations but not in crashes, have all concluded that alcohol impaired driver performance contributes to fatal crashes (NIAAA, 1984). The National Academy of Sciences estimated that if no one drove after drinking 11,000 fewer persons annually would die in crashes, approximately a 20-25% annual reduction (Reed, 1982).

Though drunken driving occurs in all age groups, it has been a particular problem among young drivers, especially young male drivers. In 1985, though they comprised less than 7% of the driving population, teenage drivers were involved in 13% of fatal crashes. Drivers under age 25 comprised only one-fifth of the driving population, but are involved in nearly 32% of fatal crashes. Drivers under age 35 comprised 45% of the driving population, but are involved in almost 60% of fatal crashes (U.S. Department of Transportation (DOT), 1987). Telephone surveys of reported driving after drinking indicate that youthful drivers are much more likely than older drivers to report driving after drinking and blood alcohol testing of fatally injured drivers supports these findings (U.S. DOT, 1987).

Drunken drivers do not pose a risk only to themselves; 20-40% of people killed in crashes involving intoxicated drivers are persons other than the drunken driver. Persons who report driving after heavy drinking are a risk not only because of slowed reaction time and poorer sensory motor coordination, but they are significantly more likely to report other risky driving behaviors. They are more likely to report driving after marijuana and other drug use, speeding, running red lights, making illegal turns, not wearing safety belts,

Table 1

Survey of Adult Drivers in Massachusetts 1985, 1986

Characteristics of Persons Who Drive After Heavy Drinking (5+ Drinks)

	Times Drove in Past Month After Heavy Drinking		
	0 N=1758	1-3 N=88	4+ N=30
Past Month			
Drove After Marijuana use	4%	18%	41%
Other Drugs	3	4	27
Wore Seat Belts 90% of the times	43	22	11
Past Week			
Ran a Red Light	8	12	18
Speed 20 MPH Over Limit	15	39	32
Past Year			
Driving Violation Other than Drunk Driving	11	29	40
Driver in Crash	9	19	19
Driver in Crash Resulting in Injury	1	2	5
Strongly Oppose			
Seat Belt Law	18	26	26
Safe Roads Act (Drunk Driving Law)	9	17	70
55 MPH Speed Limit	11	12	35

Table 2

Drunk Driving Enforcement in New England 1982-1985

	1982 N=3,314	1983 N=3,340	1984 N=3,248	1985 N=3,282
Stops After Drinking/ 1,000 D.D. Trips	11.1	16.1	21.1	33.1
Took Breath Test/ 1,000 D.D. Trips	2.5	4.6	3.4	5.9
Tickets for DWI/ 1,000 D.D. Trips	1.0	2.0	2.0	2.8
Accidents After Drinking/ 1,000 D.D. Trips	2.1	2.5	3.0	2.1

D.D. Trip = Trip after 5+ Drinks

receiving tickets for moving violations other than drunken driving, and, predictably, they are involved in more crashes and crashes resulting in injury. These drivers also oppose traffic safety legislation such as the 55 mile per hour speed limit and stiffer drunken driving laws (see Table 1). Seventy-five percent of drunken drivers under age 25 drive vehicles over 5 years of age. Passive restraints now required in new vehicles may take several years to offer protection to this population.

Strategies to Reduce Drinking Driving Fatalities Among Youth

Numerous strategies to reduce drunken driving fatalities among youth have been proposed. Some seek to separate drinking from driving but others do not, e.g., strategies such as raising driving ages, youth driver curfews, seat belt laws, requirements for crash-worthy vehicles, and better designed roadways. These latter strategies reduce drunken driving fatalities because of their overall effects on youthful crash reduction (Williams, 1987). This paper will focus specifically on interventions to reduce drunken driving and thereby reduce traffic fatalities.

Effects of the ASAP Programs in the 1970s

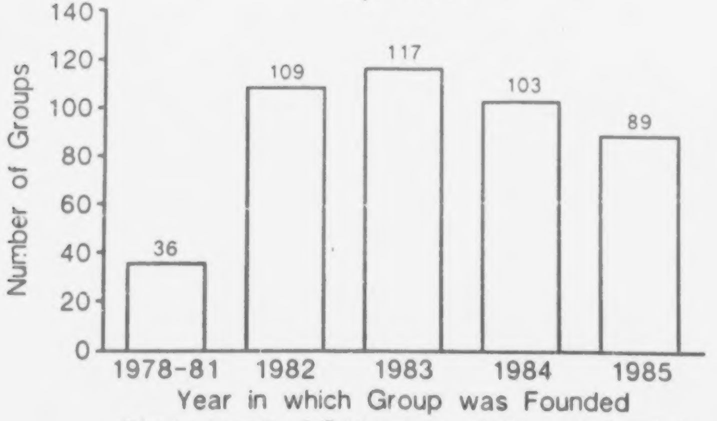
During the 1970s the most important single effort to reduce drunken driving was the Alcohol Safety Action Programs (ASAPs). The U.S. Department of Transportation invested over 88 million dollars in community programs to increase apprehension of drunken drivers and to increase counseling and alcoholism treatment to prevent subsequent driving after drinking. The emphasis for rehabilitation of those drivers derived from evidence that drivers in fatal crashes and most drivers arrested for driving while intoxicated had consumed large amounts of alcohol which were unlikely to be drunk by anyone but chronic, heavy, possibly alcoholic, drivers.

Unfortunately the impacts of the programs were variable (Nichols et al., 1978; Levy et al., 1978). Studies comparing arrested drivers offered counseling and education with drivers given standard penalties reported little difference in subsequent re-arrest and crash involvement. More recent similar studies have produced comparable results (Reis, 1983). Compared to non-ASAP control communities 12 out of 35 ASAP communities reported significant night fatal crash reductions; however, they experienced increases in fatal crashes overall. During the five years of their operation the programs were estimated to have prevented 500 fatal crashes, not as a strict result of education treatment but rather because drunken driving arrests increased, perhaps in part because police believed that arrested offenders were not as likely to be severely punished in communities relying heavily on rehabilitation and education. Even if the education and treatment programs were highly successful, it is unlikely that by themselves they would make a major impact on drunken driving fatalities. The reason is that only a very small percentage (less than 10%) of drivers involved in fatal crashes have been previously arrested for driving while intoxicated (U.S. DOT, 1987). This may be because the level of drunken driving enforcement is low. Survey data we have collected in New England suggests that drunk drivers are arrested only 2-3 times for drunken driving per 1,000 drunken driving trips. Indeed the risk of arrest per drunken driving trip is only slightly higher than the risk of crash involvement (see Table 2).

Activity to Reduce Drunken Driving in the 1980s

The persistence of the drunken driving problem and a sentiment among many persons, particularly family members whose relatives have died in drunken driving crashes, that drunken drivers were not receiving penalties commensurate with the harm they inflict on others stimulated the formation of lobbying groups to pass "tougher" drunken driving laws. The numbers of new anti-drunk driving chapters of organizations such as Mothers Against Drunken Driving (MADD) or Remove Intoxicated Drivers (RID) jumped from 2 in 1978, to 117 in 1983 (see Figure 1) (McCarthy et al., in press). During the same time frame new legislative proposals and increased police enforcement activities stimulated dramatic increases in media coverage of the drunken driving problem. According to a sample of leading national periodicals and newspaper stories media attention to the problem increased dramatically (30-50 fold increase in newspaper coverage of the problem) between 1981-1983, a period during which The President's Commission on Drunken Driving, established by President Reagan, held hearings across the nation about the problem (see Figure 2) (McCarthy et al., in press).

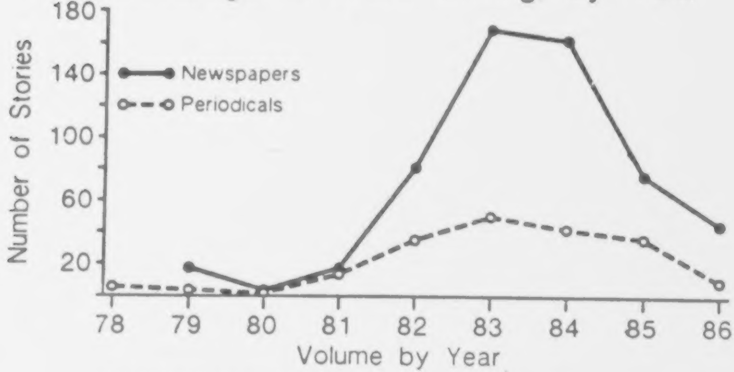
Fig. 1
Number of Anti Drunk Driving Groups Founded, By Year



(Median Length of Existence by 12/85 = 28 Months)
Source John McCarthy, Catholic University

Fig. 2

Volume of National Newspaper and Periodical Coverage of Drunk Driving, By Year



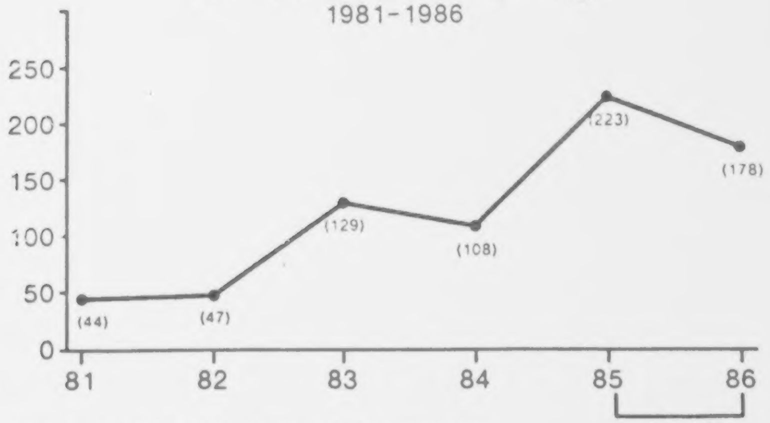
Newspaper Volume based on count of stories in the National Newspaper Index includes N.Y. Times, L.A. Times, Wall St. Journal, Washington Post
Periodical Volume based on Magazine Index

Source: John McCarthy, Catholic University

Fig. 3

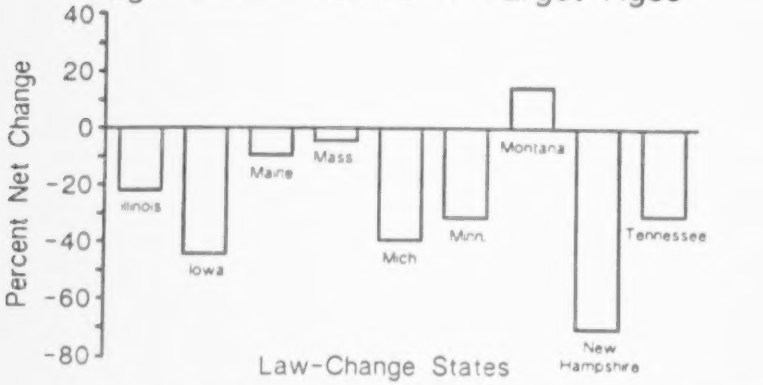
Nationwide Number of Legislative Changes to Reduce Drunk Driving

1981-1986



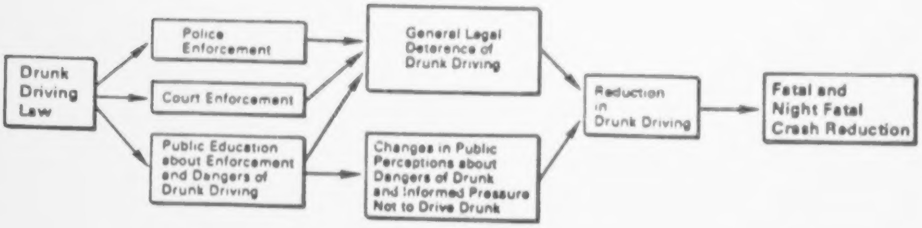
Source: S. Hatos, U.S. Dept. of Transportation

Fig. 4
Effects of Drinking Age Increases on Night Fatal Crashes in Target Ages



-Net changes in driver involvement in nighttime fatal crashes after changes in legal minimum drinking ages.

Figure 5
Potential Process of Change After a Drunk Driving Law


Drunk Driving Law
Police Enforcement
Court Enforcement
Public Education about Enforcement and Dangers of Drunk Driving
General Legal Deterence of Drunk Driving
Changes in Public Perceptions about Dangers of Drunk and Informed Pressure Not to Drive Drunk
Reduction in Drunk Driving
Fatal and Night Fatal Crash Reduction

From 1980 to 1985 over 500 pieces of drunken driving legislation were passed increasing from 44 new laws in 1981 to 223 in 1985 (see Figure 3). Over half the states raised their legal drinking age to 21; 49 states now conform to that standard. At least 30 states enacted per se legislation to facilitate conviction of drunk drivers (over 40 now have such laws). Increased penalties, license suspensions, fines, jail sentences, administrative license suspensions, and felony homicide for causing a death while driving drunk were also adopted in many states as general deterrence to drunken driving.

The balance of this paper will discuss the effects of increases in legal drinking age and per se legislation on youthful drivers.

Drinking Age Increases

The preponderance of evidence concerning the effectiveness of raising the legal drinking age suggests that this measure reduced fatal crashes 10-15% among targeted teen drivers relative to states not raising the drinking age, but crash reductions have been variable from state to state (Figure 4) (Williams et al., 1983; Du Mouchel et al., 1985; U.S. General Accounting Offices, 1987).

Few studies of legal drinking age increases have examined the full process of behaviors between passage of these laws and fatal crash outcomes (see Figure 5). Whether the laws are followed by increased police enforcement, changes in actual alcohol availability, locations and amount of drinking or the frequency that teens drive after drinking has not been routinely explored. In Massachusetts when the drinking age was raised from 18 to 20 the proportion of teens who purchased alcohol at liquor stores and bars dropped significantly from 44% to 27%, and 19% to 16%, respectively, but the portion who had others purchase for them doubled 21% to 43%. Enforcement varied widely by community. In communities of 100,000 inhabitants or more, 40% of teens, after the law, sought to purchase alcohol, but less than 10/1,000 teens were arrested. Driving after heavy drinking declined significantly, 51%-50%, relative to a comparison state and night fatal crashes among 18-20 year olds declined significantly (Hingson et al., 1983). Whether variability in effects from state to state is a function of the level of enforcement warrants consideration.

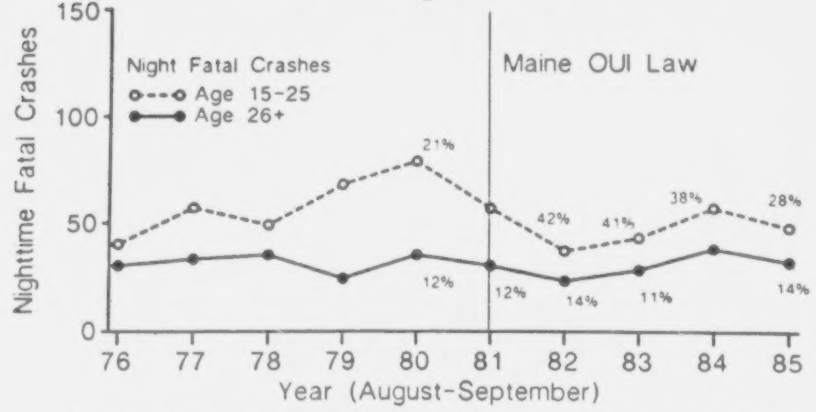
Per Se Laws

Effects of per se legislation are less clear. Studies of per se laws (Ross, 1982) in Great Britain, Canada, and France have frequently revealed transitory declines in drunk driving and fatal crashes. It is suggested that these declines were transitory because the public in those nations came to realize over time that the actual rate of conviction and apprehension was not as high as many anticipated when the laws first passed. In the United States per se laws have been studied in Minnesota, Delaware and Iowa (National Transportation Safety Board, 1986) and Administrative per se laws, where police hold a license at the time of arrest, have been studied in Oregon (Jones, 1985) and New Mexico (Ross, 1986). While the preponderance of evidence from these studies suggest they were followed by fatal crash reductions, in some the reductions occurred only after several intervening years of fatal crash increases (Minnesota). Other laws were studied only for six months to one year after implementation (New Mexico, Delaware, Iowa, Oregon). None of the above cited studies used comparison states to rule out economic or other secular trends unrelated to the laws as a reason for observed post crash declines. None of these studies sought to isolate effects on young drivers.

In Maine per se legislation was accompanied by a short term night fatal crash decline, significantly greater than experienced by other New England states (Hingson et al., 1987). The proportion of drivers reporting decisions not to drive, because they drank too much, increased significantly after the law from 14% to 20% and among males age 25 or less from 30% to 52% whereas no change on this measure was observed in the comparison state of Massachusetts. But levels of driving after drinking too much and fatal crashes returned to pre-law levels within three years. Of note, both the declines in fatal crashes after the law and then subsequent increases were observed primarily in young drivers (see Figure 6). Four factors seemed to operate in the decay of the law's effect. First, fatal and night fatal crashes were declining before the law was enacted. A similar finding was observed by Preusser et al. in Wisconsin (Preusser et al., in press) and in Massachusetts (Hingson et al., 1987) before drunken driving laws there. In Massachusetts two surveys, conducted one year apart, before the Massachusetts 1982 law passed indicated declines in drunken driving occurred there before passage of the new law even though the public thought enforcement was diminishing. That suggests the media attention to drunken driving that precedes a new law and often dissipates shortly after a law may stimulate informal social pressure not to drive drunk and that in turn may be as important as the laws themselves.

Second, the perceived likelihood of drunk drivers being stopped and charged was not significantly increased after the law. As noted earlier in Maine, as in the rest of New England, the risk of arrest is only around 3/1,000 drunken driving trips reported by respondents.

Fig. 6
Nighttime Fatal Crashes-Maine by Age of Youngest Driver



% refer to respondents who decided not to drive because of drinking.

Third, while Maine citizens recognized that the law increased convictions for drunken driving and that mandatory jail sentences, license suspensions and fines were more likely after the law, the proportions that believed these penalties were severe increased from 20% before the law to 37% the year after the law, but returned to the pre-law level by the third post-law year. Possibly Maine citizens became accustomed to the new penalties.

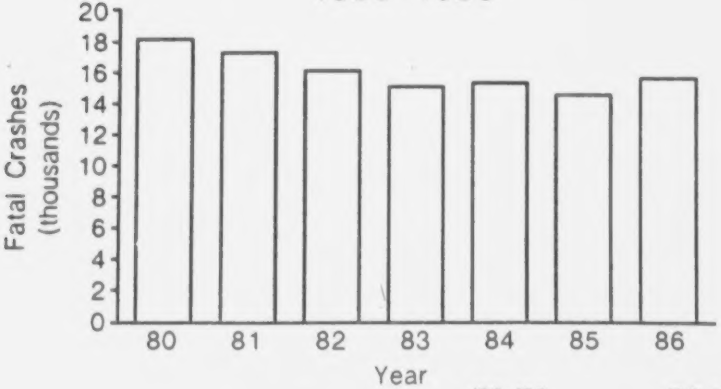
Fourth, Maine drivers, particularly those who drink, perceived a drop off in speed enforcement after the drunken driving law. State police speed arrests declined one-third from the year before the law to the third post-law year. According to Federal Highway Monitoring equipment the proportion driving 65+ in 55 per mile hour zones increased from 7% to 12%. When informed of this trend Maine police instituted a speed crackdown increasing stops 100% and arrests 30%. Fatal crashes which had been increasing for two years declined 16% from 1984 to 1985. Because of their slower reaction time and slower sensory motor coordination drunk drivers may be particularly vulnerable to crashes at higher speeds. (Maine's experience may foretell national trends since 38 states raised their speed limits in 1987.)

National Trends 1980-1985 (Figures 7, 8, 9)

The Maine drunken driving data clearly reflect national fatal crash data. From 1980 to 1985 when the increase in media attention, community organization and legislative activity concerning drunken driving crescendoed, fatal crashes declined 13% from 45,284 in 1980 to 39,168 in 1985. Single vehicle night fatal crashes, those most likely to involve alcohol, declined even more sharply, down 20%, from 18,277 to 14,603. Among teen drivers, 15 to 19 years the overall crash decline was steeper, down 34%, from 3,693 to 2,408. But from 1985 to 1986 the trend reversed. Fatal crashes, particularly single vehicle night fatal crashes, increased, and increased more among teens than among drivers of older ages. Fatal crashes among all ages rose 5%. Single vehicle night crashes rose 7%, 14,603 to 15,663 (up 1,060). Teen fatal crashes rose 10% from 7,091 to 7,793 and teen single vehicle night fatal crashes rose 17% from 2,408 to 2,820 (up 412). The U. S. DOT estimates that teen alcohol-related traffic fatalities increased 14% in 1986 relative to 1985 and adult alcohol-related fatalities 7%, whereas all other fatalities increased 3%. These increases occurred after several years of decline (U.S. DOT, 1987).

Fig. 7

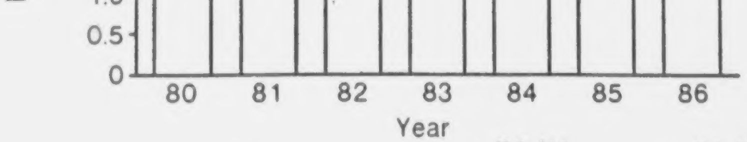
SVN Fatal Crashes Nationwide, All Ages
1980-1986



		'80-'85		'85-'86
SVN Crashes	3,674	↓ 20%	1,894	↑ 7%
Other Crashes	2,442	↓ 9%	834	↑ 3%

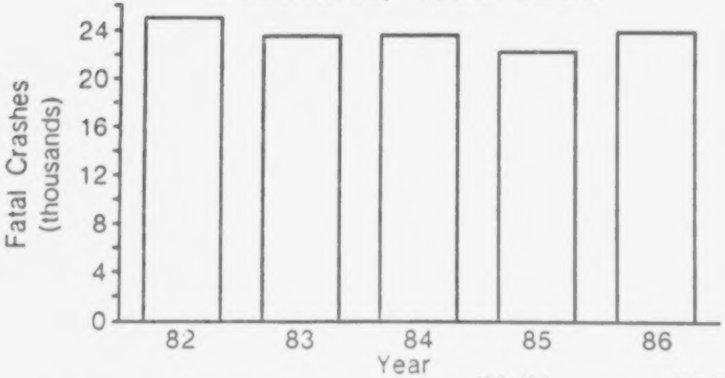
Fig. 8

Teen SVN Fatal Crashes Nationwide
1980-1986



		'80-'85		'85-'86
SVN Crashes	2,497	↓ 34%	702	↑ 17%
Other Crashes	1,212	↓ 20%	290	↑ 6%

Fig. 9
Alcohol Related Traffic Fatalities
Nationwide, 1982-1986



		'80-'85		'85-'86
Alcohol Related Fatalities	2,810	↓ 11%	1,630	↑ 7%
Non-Alcohol Related Fatalities	1,690	↓ 14%	601	↑ 3%

Source US Dept of Transportation

Discussion

Isolating the effects of laws to deter drunken driving is difficult for several reasons. First, so many laws are passed within short periods of time (over 500 nationwide from 1980-1985) that it is difficult to distinguish the effects of each law. Second, our dependent variable measures lack precision. Only in the last 2 to 3 years have half of the states tested the blood alcohol of half the drivers in fatal crashes. Moreover, less than half of drivers in fatal crashes involving alcohol are themselves killed. In the absence of comprehensive testing that would permit comparing fatal crash trends among intoxicated relative to non-intoxicated drivers, researchers have relied on proxy measures such as single vehicle night fatal crash rates as a surrogate of alcohol involvement. Two-thirds of single vehicle night crashes in states with comprehensive testing of blood alcohol in fatal crashes involve intoxicated drivers compared to one-third of day time crashes. Unfortunately single vehicle night crashes are a rather insensitive measure of alcohol involved crashes because less than half of all crashes involving an intoxicated driver are single vehicle night crashes. While this measure has greatest applicability over multiple states, it should be used cautiously in single state comparison or age groups comparisons within states, particularly over short time frames (Heeren et al., 1985). Third, independent and intervening variable measures in many studies are problematic. Most studies of drinking age changes have not monitored teen drinking and few have examined enforcement. Levels of driving after drinking are often derived from telephone surveys where bias in the form of underreporting can be a concern. The expense and difficulties of roadside surveys have minimized their use in these studies. Similarly arrest data and conviction data tend to vary in quality from state to state and within states over time. In addition mileage data on teen versus adult travel is not systematically recorded.

Changes in the economy are also thought to influence fatal crash trends. As the economy worsens young and blue collar drivers may have less discretionary income for recreational driving or purchasing alcohol at bars. That will lower drunken driving trends. Although the Maine study controlled for unemployment rates, many studies have not.

Nonetheless, some common threads can be drawn from these studies. Increases in drinking age appear to reduce, but clearly not eliminate, drunken driving and fatal crashes among teens. Enforcement of drinking age laws, where studied, appears to be minimal. Teens who want to drink appear to have little difficulty either finding older friends to purchase for them or finding liquor outlets where they will not be carded for age identification. Now that teen traffic fatalities have begun to rise despite almost all states having drinking ages of 21, alternative strategies to reduce teen drinking will warrant attention. Increased enforcement prohibiting teenage purchase of alcohol deserves study as do social host liability statutes targeting those who purchase alcohol for teens.

Similarly, per se type laws also hold potential for reducing drunken driving among youthful drivers. But again enforcement is an important concern. It is not clear whether such laws can achieve long term declines in drunken driving if the public does not perceive a high likelihood that drunken drivers will be stopped. The international experience, the study in Maine and current national data raise doubts about the long term potential of general deterrence with low numbers of arrests. Yet several community studies have shown increased drunken driving arrest programs can reduce traffic fatality rates (Voas and Hause, 1987; Lacey et al., 1986; Voas et al., 1986). A crucial question is how to increase public support not only financially but also in terms of citizen backing for more intensive sustained police drunken driving enforcement.

Finally, the Maine study underscores the importance of law enforcement officials recognizing the interrelatedness of many traffic safety behaviors. People who drive drunk as a group are more likely to speed, not wear safety belts, run red lights, have other moving violations, drive after drug use and be in crashes resulting in injury. Focusing attention on one area of drunken driving while relaxing attention on others such as 38 states recently have done by raising speed limits may compromise the long-term beneficial effects of drunken driving laws. Studies of the effects of seat belt laws (Williams and Lund, 1986; Hingson et al., 1988) have similarly found that drunken drivers and speeders are less likely to adopt belt use thereby diminishing the beneficial effects of belt laws.

Risky driving behavior among youth comprises a complicated set of interrelated behaviors. While drinking age laws and general drunken driving deterrence laws such as per se legislation show promise for reducing teen crashes, multiple risky driving behaviors must be approached simultaneously and enforcement increased, sustained and supported by the public over time if long term fatality and injury reductions are to be sustained.

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